EVALUATION OF FEE WAIVER SCHEME EFFECTIVENESS IN IMPROVING HEALTH CARE ACCESS TO THE POOR SEGMENTS OF THE POPULATION IN ADDIS ABABA, ETHIOPIA.

BY

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ABSTRACT

Background: Availing equitable and affordable health services for citizens is becoming a problem for governments of developing countries. In Ethiopia, the government has been implementing fee waiver scheme since 1998 to advance the health access by the poor, though it is still a crucial challenge of the health sector.

Purpose: The intent of the study was to evaluate the effectiveness of fee waiver scheme in improving access to health by the poor in Addis Ababa and to propose implementation framework to improve its outcome.

Method: This study employed qualitative research approach to evaluate the program effectiveness and to propose implementation framework in two phases. Exploratory and descriptive case study designs, and Delphi techniques were utilized to evaluate the scheme's effectiveness and to validate the proposed implementation framework. The researcher employed purposive and convenience sampling methods to sample the study populations, and used Atlas ti 7.5 software to analyze the findings.

Result: This study revealed that the commencement of the scheme has benefited considerable poor population in the city. However, its effectiveness in terms of addressing the needy population, services coverage and protecting the poor from

financial hardship is not yet achieved. Poor health facilities capacity, poor program management and lack of comprehensive monitoring and accountability system were found major factors that affected its success. As a result, the researcher proposed an implementation framework with the aim of addressing these problems.

Conclusion: Achieving Universal Health Coverage without addressing the indigents' health need is impossible. Lack of comprehensive health services, in adequate population coverage and poor financial protection were among the major findings. Hence, prior attentions should be given to equip health facilities with necessary infrastructures and ensure the inclusion of all needy populations through effective monitoring, governance and leadership mechanisms to improve its intended outcomes. If utilized properly, the findings and the implementation framework of this study will serve as valuable resources for immediate decisions and directions by the policy makers.

Keywords:

Access, evaluation, framework, effectiveness, Indigents, poor, healthcare, population, qualitative, exploratory, descriptive

DECLARATION

I declared that **EVALUATION OF FEE WAIVER SCHEME EFFECTIVENESS IN IMPROVING HEALTH CARE ACCESS TO THE POOR SEGMENTS OF THE POPULATION IN ADDIS ABABA, ETHIOPIA** is my own work and all the resources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institutions.

_____ **November 02 2019**

ZEMICAEL MEKONEN HAGOS **Date**

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DEDICATION

This study is dedicated to my mother Letensie Ekubay and my father Mekonen Hagos for their ability to see light in a far tunnel through education and their sacrification to get their children advanced in academic careers.

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LIST OF ABBREVIATIONS

AA……... Addis Ababa

AACAHB…. Addis Ababa City Administration Health Bureau

AACA……...Addis Ababa City Administration

CBHI ……. Community Based Health Insurance

CIPP ….....Context Input Process Product

EHSFR……Ethiopian Health Services Financing Reform/

FGD…… Focus Group Discussion

FWS……Fee Waiver Scheme

FMOH. ….. Federal Ministry of Health

HFG……Health Financing and Governance

HSTP……. Health Service Transformation Plan

HSDP……. Health Service Development Plan

KII ……. Key Informants Interview

MDG...……Millennium Development Goal

MOH…..... Ministry of Health

PHCU……. Primary Health Care Unit

SDG…….. Sustainable Development Goal

SO…...……Strategic Objective

SSA…...…. Sub Saharan Africa

TGE…….. Transitional Government of Ethiopia

UHC……. Universal Health Coverage

UN…….. United Nations

UNISA…. University of South Africa

WB……. World Bank

WHO..…. World Health Organization

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CHAPTER ONE

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

In developing nations, management and financing of health systems is becoming a critical issue for health system policy makers (Kai 2015:16). The problem of severely under funded health systems have caused the government of these societies including several in sub Saharan Africa to face with a dilemma as to the best option of getting their citizenry access to affordable health services (Manortey 2013:33).

While working in such health policy developments, policy makers need to be conscious in terms of ensuring the delivery of equitable health service to the poor population in their respective countries (Maluka 2013:6). Besides, the designing and implementation of pro poor health financing interventions need to be based on evidences that can practically address the existing contextual and societal health problems (De Allegri, Sauerborn, Kouyate & Flessa 2009 cited in Bonfrer 2015:174-75).

Cognizant of the poor health service delivery due to under financed health system in the country, the Ethiopian council of ministers approved a health care financing strategy in 1998 (FMOH 2014:31). The strategy aimed at improving health services quality in a sustainable way through improved resources mobilization and management systems. Fee waiver scheme, one component of this strategy, is a pro poor health care financing mechanism targeting households or individuals who fall in the category of the last under poverty margin identified by their respective administration. The cost of these services will be covered by a third part usually the government (FMOH 2014:31).

Despite such investments and efforts, addressing the health demand of the poor population and protecting the poor from financial difficulties due to medical expenditure is still a challenge. Hence, this research explored and described the fee waiver implementation situation and developed fee waiver implementation framework in two phases to achieve the expected outcome of the scheme.

Qualitative research design with exploratory and descriptive case study designs were used to evaluate the knowledge, perceptions and experiences of the study participants during phase one. During phase two, the researcher used the themes that were developed during phase one as an input and designed an implementation framework using Delphi technique. Purposive and convenience sampling methods to sample the study population and study sites were employed during phase one. Health facilities and woredas with the highest fee waiver beneficiaries one year prior to the data collection period and staffs of these institutions who have at least one-year experience on fee waiver scheme were selected purposively.

Similarly, fee waiver beneficiaries who came to the health facilities during the data collection time and who have been using the service for at least one year were selected using convenience sampling method. Focus Group Discussions (FGD) and Key Informant Interviews (KII) were applied to collect the data through experienced data collectors; namely the researcher of this study and a PhD holder senior researcher. Then, the researcher employed qualitative data analysis software, Atlas ti 7.5, to analyze the study findings.

During phase two, the researcher in collaboration with experienced professionals developed an implementation framework based on the findings of phase one. These professionals have been coordinating and implementing the fee waiver scheme at all administrative levels starting from ministry of health up to woreda health offices.

Therefore, the findings of this study revealed that the implementation of fee waiver scheme has made significant contribution in saving lives of many poor populations in the city. However, its effectiveness in terms of reaching the needy population, provision of comprehensive health care services and protecting the poor from the financial difficulties due to medical expenditure is by far not achieved. Hence, the researcher developed fee waiver implementation framework that could potentially enhance the effectiveness by addressing the limitations investigated during phase one. The researcher believed the findings of this study will have significant contribution for the formulation and strengthening of pro poor health care policies and strategies and could enable Ethiopia achieve Universal Health Coverage (UHC).

1.2 BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLEM

1.2.1 The source of the research problem

1.2.1.1 Ethiopia: Country overview

Ethiopia is the oldest independent and second most populous country in Africa. It has a unique cultural heritage with a diverse population mix of ethnicity and religion. It served as a symbol of African independence throughout the colonial period and was founding member of the United Nations and the African base for many international organizations (FMOH 2016:18).

Its topographic features range from the highest peak at Rasdashen, 4550 meters above sea level, down to the Afar depression, 110 meters below sea level (CSA, 2009). The climate varies with the topography, from as high as 47 degrees Celsius in the Afar depression to as low as 10 degree Celsius in the highlands. Ethiopia's total surface area is about 1.1 million square kilometers. Djibouti, Eritrea, the Republic of Sudan, the Republic of southern Sudan, Kenya, and Somalia border the country (CSA 2012:22).

1.2.1.2 Ethiopia health situation

Ethiopia had no health policy until early 1960s. When a health policy initiated by the World Health Organization (WHO) was adopted in the mid1970s, during the Derg regime, a health policy was formulated with emphasis on disease prevention and control which gave priority to rural areas and advocated community involvement. The current health policy promulgated by the transitional government takes into account broader issues such as population dynamics, food availability, acceptable living conditions and other essentials of better health (TGE 1993:2).

To realize the objectives of the health policy, the government established the Health Sector Development Program (HSDP), which is a 20-year health development strategy implemented through a series of four consecutive 5-year investment programs (CSA 2012:25).

In the past 20 years, the government of Ethiopia through its HSDP, has invested heavily on health system strengthening guided by its pro poor health policies and strategies resulting in significant gains in improving the health status of Ethiopians (FMOH 2016:12). As a result, the country has done remarkably well in meeting most of the Millennium Development Goals (MDG) targets. Some of the notable achievements include achievement of MGD-4 with a 67 percent drop in under five mortalities, an increase in life expectancy at birth from 45 in 1990 to 64 years in 2014 and a 69 percent decrease in maternal mortality from 1990 to 2014 (FMOH 2016:13).

The HSDP prioritizes maternal and newborn care, and child health, and aims to halt and reveres the spread of major communicable disease such as HIV/AIDS, TB, and malaria. The Health Extension Program (HEP) serves as the primary vehicle for prevention, health promotion, behavioral change communication, and basic curative care. It serves as an innovative health service delivery program that aims at universal coverage of primary health care. The program was based on expanding physical health infrastructure and developing health extension workers (HEWs) who provide basic preventive and curative health services in the rural community (CSA 2012:25). To this effect, 16,440 health posts, 3,547 health centers, and 311 hospitals have been constructed over the last 20 years (FMOH 2016:14).

Building on the lessons learned in implementing the earlier plans and to be highly responsive to the current socio economic landscape, the government has developed Health Sectors Transformation Plan (HSTP) 2015/16-2019/20 which is part of the second Growth and Transformation Plan (GTP II). This HSTP envisions “Ethiopia’s path to Universal Health Care through strengthening of primary health care”. It has three key features: quality and equity, Universal health coverage and Transformation (FMOH 2016:13).

1.2.1.3 Ethiopia health care reform: Fee waiver scheme

The Ethiopian council of ministers approved a health care financing strategy in 1998 to increase the availability of health resources in a way that would improve equity and sustainability and lead to improved quality of care (FMOH 2014: 31). Core components of the financing strategy include; revenue retention and utilization, fee waiver scheme, exemption of selected health facility services and user fee revisions (AACAHB 2009:39-40).

The fee waiver system, the subject of this study, is a system that ensures that people pay for health services according to their ability to pay, protecting the "poorest of the poor" (households or individuals who fall in the category of the last margin of the under poverty level) from the financial barriers to seeking health services by covering the cost of fee waivers by an appropriate third party (FMOH 2014:31).

Eligible beneficiaries are screened and identified through community participation and the selected beneficiaries are given a certificate entitling them to free health services. The woreda administrations are now budgeting to cover the cost, entering agreements with health facilities, and reimbursing health facilities for services rendered to the fee waiver beneficiaries. This is based on the principles of no service is "for free" and is intended to link the body issuing the fee waiver certificate with the payment (USAID 2011:44).

There have been improvements over the last few years in government allocation for fee waivers to facilitate access. Total subsidy for the poor has reached more than 20 million Birr so far. The number of fee waiver beneficiaries has also reached 2 million (FMOH 2016:50-51). The 2010/11 National health Account (NHA) shows Ethiopia's health care financing reform has yielded tremendous achievements.

A 300% increase in total health expenditure has been measured as well as an increase in per capita health expenditure from $7.10 in 2004-5 to $20.77 in 2010-11(USAID 2016 1-2). Besides, in regions, where standardizations of fee waiver system and packages of exempted services have been successfully accomplished, inequities in access to care have been reduced. However, though these progresses are encouraging, the fee waiver

scheme implementation so far covers less than 10% of the total population that lives below the poverty line in the country (FMOH 2016:50-51).

To cope with these challenges, the government of Ethiopia is introducing two types of health insurance: Community Based Health Insurance (CBHI) and Social Health Insurance (SHI). The health sector transformation plan of the country (2015/16-2019/20) also highlights a need for increased government budget allocation to the health sector continued strengthening of health care financing reforms, and the introduction of innovative domestic financing mechanisms to deliver towards the goals of Universal Health Coverage (UHC) (USAID 2016).

1.2.2 Back ground of the research problem

According to Adam, Gabriela, Justine, Mark-Francois, Kateryna, Leander, KimVan and Patrick (2017:5), about 808 million people incurred catastrophic spending in 2010 globally. Similarly, a report from WHO and World Bank (2017:11), showed that the estimated impoverished population due to health care at the 2011PPP$1.90 a day poverty line was ninety-seven million. Hence, an urgent call from the UN general assembly was delivered to governments to invest towards Universal access to affordable and quality health care services to all citizens regardless of their ability to pay.

However, availing and managing of health care resources still remained a problem for the developing nations (kai 2015:16). Against a backdrop of severely under funded health systems, government of these societies including several in sub Saharan Africa are faced with a dilemma as to the best option of getting their citizenry access to affordable health services (Manortey 2013:33).

Inadequate financial protection and lack of accessibility have been documented in many health equity studies as factors influencing use of health care services by the poor and rural population (Mwandira 2012:15). Attempts to use the user fees system to finance health care delivery seems in many cases have presented several barriers to access, causing many of the people to change their health care service seeking behaviors to the detriment of their lives (Manortey 2013:33) and they spend a greater proportion of their income on treatment than non-poor households do (Mwandira 2012:15).

Therefore, targeted public health insurance programs are important forms of social support that many countries adopt to help poor people. Such programs have become increasingly common in the recent years in a number of middle and low income countries (Nguyen 2010:20). However, the choice for specific health care financing interventions seems to be driven more by "fashion trends" than by reliable evidences on its effectiveness in most cases. The fact that more than 900 health insurance schemes were implemented a few years ago across Sub Saharan Africa (De Allegri, Sauerborn, Kouyate &Flessa 2009), while the robust scientific evidences on their effectiveness is limited and can be difficult to interpret (Bonfrer 2015:174-75).

In an attempt to decrease barriers to health care access for poor citizens, fee waiver and exemptions systems have been introduced. However, these systems have had limited success in generating the resources and infrastructures that are necessary to provide care to all who need it or to sufficiently mitigate costs for resources challenged families (Akazili, Gyapong & McIntyre 2011:26). Hence, it was found that pro poor health policies with the public sector, for example universal coverage, exemptions and waivers have been found to be relatively in effective in protecting the poor (Mwandira 2012:15).

Similarly, Ethiopia has been facing the same problem though its council of ministers approved a health care financing strategy in 1998 with aim of improving health service quality through improved resources mobilization and allocation (FMOH 2014:31). Fee waiver scheme, the main component of this study and the subject of this study, was designed to improve access of health care to the poor segments of the population with a third party covering the costs (AACAHB 2009:39-40). This is based on the principles of no service is "for free" and is intended to link the body issuing the fee waiver certificate with the payment (USAID 2011:44).

However, addressing the health care needs of the poor is still a major problem in the country. So far, the fee waiver scheme benefited less than 10% of the country's poorest population (FMOH 2016:50-51). Besides, households' expenditure for health is becoming very high that it can be prohibitive to many households and catastrophic to others (FMOH 2014: 94). The mean medical expense was 432 birr ($22.46 USD) per patient per visit which is more than the national health expenditure per capita. Likewise, studies showed that "59% of the households with any type of illness were facing a difficult problem in

finding money for medical expense and 65% of them were making money for health care by selling capital assets" (Adane, Measho & Mezgebu 2014:5), which shows the existence of medical impoverishment.

1.3 PROBLEM STATEMENT

Against a backdrop of severely under funded health systems, government of developing countries including several in sub Saharan Africa are faced with a dilemma as to the best option of getting their citizenry access to affordable health services (Manortey 2013:33). Availing and managing of health care resources still remained a problem for these nations (kai 2015:16).

Despite the fact that the government of Ethiopia has been implementing the fee waiver scheme since 1998 to enhance the financial risk protection and improve the health care access by the poor society (FMOH 2014:31), improving health care access by the poor society and enhancing the financial risk protection is still one of the major challenges for the health system in Ethiopia (FMOH 2014:31).

This scheme still served less than 10% of the total poorest population in the country (FMOH 2016:50-51). Similarly, study showed 59% of the households with any type of illness are facing a difficult problem in finding the money for medical expense and 65% of them are making money for health care by selling capital assets (Adane, Measho & Mezgebu 2014:5). Besides, there were no studies conducted to assess whether this scheme is heading towards achieving its intended outcomes i.e. Improving health care access by the poor population of Addis Ababa city or not.

Therefore, this study's purpose is to explore the effectiveness of fee waiver scheme in improving health access for the poor segments of the population and propose implementation framework that could support for the achievements of the desired outcomes.

1.4 AIM OF THE STUDY

1.4.1 Research purpose

The purpose of the study is to evaluate the effectiveness of fee waiver scheme in improving health access by the poor population in Addis Ababa and to develop and propose FWS implementation framework to improve the intended outcomes.

1.4.2 Research objectives

- Explore and describe the experiences and perceptions of the fee waiver beneficiaries and implementers on the effectiveness of the fee waiver scheme in improving health care access for the poor segments of the population in Addis Ababa Ethiopia.
- Develop and Propose fee waiver scheme Implementation framework to improve health care access for the poor segments of the population in Addis Ababa Ethiopia.

1.5 SIGNIFICANCE OF THE STUDY

This study has generated reliable evidences for decision makers on the fee waiver scheme implementation status, limitations that affected its effectiveness, and the existing opportunities that could be exploited. The researcher has also developed an implementation framework that is expected to address the existing implementation challenges. Achieving Universal Health Coverage (UHC), the country's primary goal, will only be realized if the health care demands of the poor are well addressed. Hence, the outputs of this study will serve as valuable references and resources to play a crucial role during the government's effort to t improve access for health care by the poor which will lead to the achievement of UHC.

Furthermore, it will also add value to the field of health economics and health service management at a theoretical as well as a methodological level by providing new scientific knowledge to the scientific community who are studying or implementing on areas of health care financing or pro poor health services financing strategies.

1.6 DEFINITIONS OF TERMS

Evaluation: According FSN (2015:24), evaluation is "a systematic collection and analysis of information about the characteristics and outcomes of programs and projects as a basis for judgement to improve the effectiveness and/or inform decisions about current and future programming". In this study, evaluation is referring to the assessment of fee waiver scheme effectiveness in improving the health access for the poor segments of the population in the city. This evaluation was conducted from the perspectives of the beneficiaries' and the implementers' through which the output is expected to serve as resources and evidences for the government for policy improvements.

Fee waiver scheme: "is a system that ensures that people pay for health services according to their ability to pay, protecting the poorest of the poor (households or individuals who fall in the category of the last margin of the under poverty level by the administration of their province) from the financial barriers to seeking health services by covering the cost of fee waivers by an appropriate third party" (AACAHB 2010:42; FMOH 2014:31). The beneficiaries are screened and selected by the community and government representatives using preset screening criteria.

Access: Access to health care or its accessibility is often regarded as an important determinant of the equity of a health care system. It is absence of any element that constitutes a barrier whether or not that barrier takes a monetary form or can be converted in to a monetary form. These barriers can be: financial, physical, institutional or social (Culyer 2005:4).

In this research, access for health care refers to the ability of the poor segments of the population to get the desired or demanded health care services regardless of their financial ability to pay. Individuals' financial capacity should not be a reason for not getting the health services, despite their demand is there.

Access to health care or its accessibility is often regarded as an important determinant of the equity of a health care system. It is absence of any element that constitutes a barrier

whether or not that barrier takes a monetary form or can be converted in to a monetary form. These barriers can be: financial, physical, institutional or social.

1.7 THEORETICAL FOUNDATIONS OF THE STUDY

1.7.1 Research paradigm

Johnson and Christensen (2014:79), describe research paradigm as scientific community's world view that is based on common hypothesis and principles. Paradigm for human inquiries are often characterized in terms of the ways in which they respond to basic philosophical questions such as what is the nature of reality (ontological) and what is the relationship between the inquirer and those being studied (epistemological) (Polite & Beck 2012:11). This study is founded in a constructivist word view that the philosophy of this study is well suited with this worldview.

1.7.1.1 Constructivist / Interpretivism / world view

Constructivism or social constructivism (often combined with interpretivism) is a perspective that is typically seen as an approach to qualitative research (Creswell 2013:38). This study employed qualitative research approach to explore and describe the participants' experiences and perceptions about the effectiveness of the fee waiver scheme in improving health care access for the poor population in Addis Ababa city. The goal of researches that are founded under this perspective is to rely as much as possible on the participants' views of the situations being studied (Creswell 2013:38).

Similarly, the researcher under this study gathered the broad and general understandings and thoughts about the fee waiver implementation, and constructed meanings about the situation from the complex ideas generated. Hence, this constructivist perspective is appropriate to this study.

1.7.1.2 Assumptions of the study

Polite and Beck (2012:720) describe assumption as “a principle that is taken for granted or accepted as being true based on logic or faith without proof or verification” (Polite &Beck 2012:720). Often in research, assumptions are made to justify methodological strategies which have not been tested. In this study, it is assumed that the implementation of fee waiver scheme in Ethiopia is not as effective as it was intended in making health care accessible to the poor. Besides, it was assumed that impact evaluation of the program has not been conducted to assess its effectiveness and its efficiency. Thus, the researcher found it critical to further explore and verify the assumptions.

1.7.1.2.1 Ontological assumptions

According to Johnson and Christensen (2014:866), ontological assumption deals with the nature of reality and truth as perceived by the individual. The core assumption of this study was the thoughts and opinions of the fee waiver beneficiaries and the implementers reveal the existing reality about the fee waiver implementation process and its effectiveness. Hence, the ontological assumption of this research was: The fee waiver scheme was not addressing the health care needs of the target beneficiaries and the poor were not financially protected.

1.7.1.2.2 Epistemological assumptions

Epistemological assumption is a philosophical assumption that deals with knowledge and its justification (Johnson &Christensen 2014:853). Straubert and Carpenter (2011:455) also defined it as a branch of philosophy that is concerned on how individuals determine what is true.

In this study, the researcher conducted Key Informant Interview (KII) and Focus Group Discussion (FGD) with the fee waiver scheme beneficiaries, health service providers and service buyers to explore the perception, experience and feelings about the scheme.

While collecting the data, the data collectors have carefully listened the study participants and recorded every non-verbal action to make sure what they said is similar to it. Besides, the familiarity of the researcher with the culture and livelihood of study population has helped him clearly understand the reality of the case under study.

1.7.1.2.3 Methodological assumption

Methodology refers to the identification, study and justification of research methods (Johnsen &Christensen 2014:863). Under phase one of this study, using qualitative research approach with exploratory and descriptive case study design is methodologically assumed to be effective in revealing the real situation of the fee waiver scheme implementation and its effectiveness on the ground. Moreover, the utilization of delphi technique in phase two was also considered as methodological assumption to validate and propose implementation frame work

Furthermore, purposive sampling method, ensuring the quality of the data collection process and proper management of the data analysis procedures are further assumptions that could assist the researcher discover the real phenomenon on the ground in terms of the fee waiver effectiveness in achieving its intended objectives.

1.7.2 Theoretical framework

A theory is “an explanation or explanatory system that discusses how a phenomenon operates and why it operates as it does” (Johnsen & Christensen 2014:881). Similarly, Given (2008:869) define a theoretical framework as any empirical or quasi empirical theory of social and/or psychological process at a variety of levels (e.g. Grand, Mid-range and explanatory) that can be applied to the understanding of phenomena.

This study utilizes Context, Input, and Process and Product (CIPP) program evaluation model as presented by Daniel Stufflebeam (2003:3) to evaluate the effectiveness of the fee waiver scheme in improving the health care access for the indigent population in Addis Ababa city.

The CIPP model is a comprehensive frame work for guiding formative and summative evaluations of projects, programs, institutions and systems (Stufflebeam 2003:3). It is

configured for use both by internal and external evaluators. The core components of the CIPP model include Context, Input, Process and product.

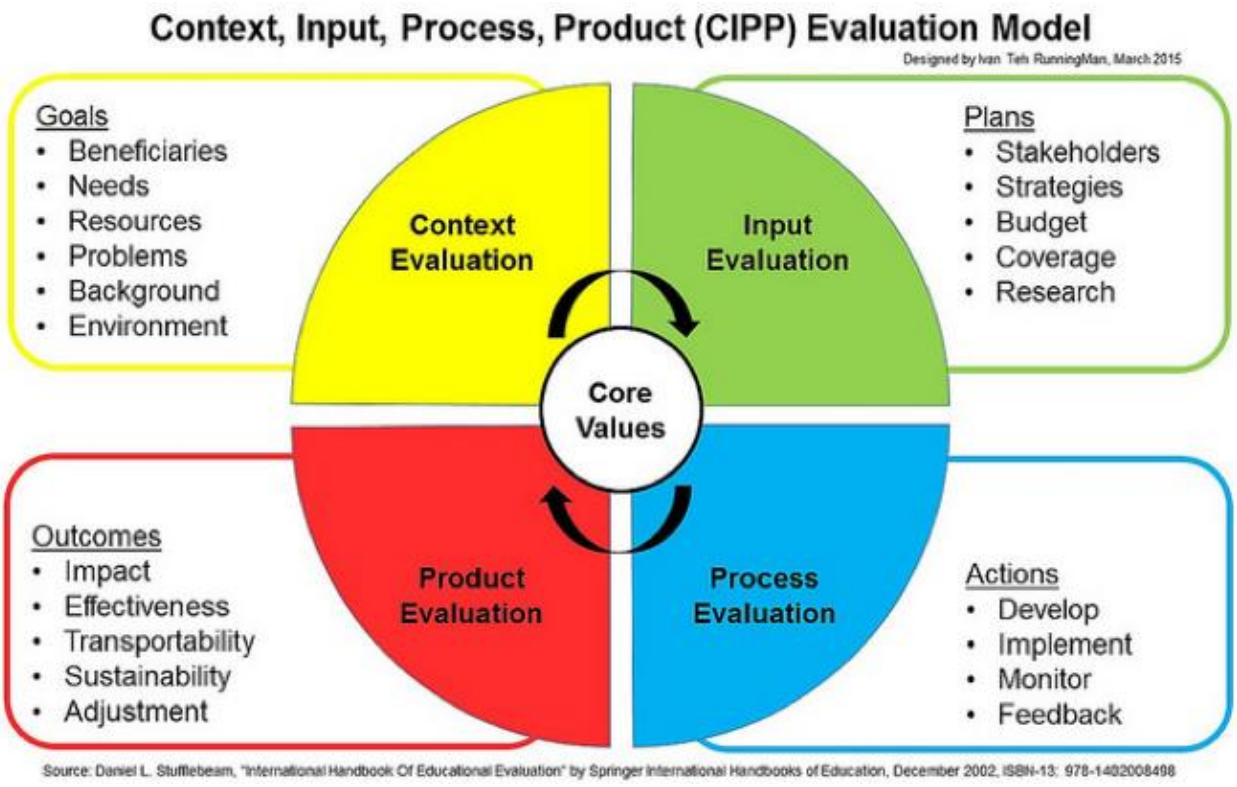

Figure 1.1 Daniel Stufflebeam's Program evaluation (CIPP) model

Context Evaluation: This component examines and describes the context of the program being evaluated. It assesses the needs, problems and existing opportunities that can directly or indirectly affect the program implementation. It also helps decision makers define goals and priorities and examines if the program objectives are responsive to the identified needs.

In this research, the researcher assessed the needs of the beneficiaries and implementers, existing opportunities and prevailing problems that can inhibit the implementation of the fee waiver scheme in Addis Ababa city.

Input Evaluation: Examines the availability of necessary strategies, procedures, infrastructures, and supplies for the feasibility and potential cost effectiveness to meet targeted needs and goals. It also helps guide program planning and make program

structuring decisions. Similarly, in this study, the availability of implementation manuals, strategies, drugs, medical equipment are assessed. Besides, the existence of robust monitoring and evaluation system and political commitment are examined.

Process Evaluation: Evaluates the implementation of plans to help staffs carry out activities and later help the broad group of users' judge program performance and interpret outcomes. In this study, the process evaluation mainly focuses in evaluation the stakeholders' engagement and management, assess screening approaches, service provision and expenditure reimbursement process. Besides, the bilateral agreements among regions, zones, woredas, and health facilities and the monitoring and evaluation process of the program implementation are evaluated under this component.

Product Evaluation: According to Stufflebam (2003:4) the process evaluation Identifies and interprets outcomes that are intended or unintended, and short or long term outcomes both to help staffs keep an enterprise focused on achieving important outcomes and ultimately to help the broader group of users gauge the efforts' success in meeting the needed targets.

In this study, the researcher assessed the general and specific outcomes of the fee waiver scheme. Improvement of health care access by the poor in terms of population coverage, services coverage and financial protection are evaluated and examined accordingly.

1.8 RESEARCH DESIGN AND METHOD

According to Johnson and Christensen (2014: 875) description, research design is the outline, plan, or strategy that is used to answer research questions. Similarly, Creswell (2013:295) describes it as a research method that involves the forms of data collection, analysis and interpretation that researchers propose for their studies.

In this study, the researcher used qualitative research approach with exploratory, descriptive and case study designs to explore the effectiveness of the fee waiver scheme in addressing the health care needs of the poor society in Addis Ababa.

1.9 SCOPE OF THE STUDY

The evaluation of the fee waiver scheme will be only from the perspectives of fee waiver beneficiaries and the implementers. Besides, the study will be conducted in Addis Ababa and will not be transferable to other regions.

1.10 STRUCTURE OF THE DISSERTATION

This study is structured as follows:

- Chapter 1: Orientation of the study
- Chapter 2: Literature review
- Chapter 3: Research Design and Method
- Chapter 4: Analysis, Presentation and Description of the Research Findings
- Chapter 5: Discussion
- Chapter 6: Development of Strategies
- Chapter 7: Conclusion and Recommendations

1.11 CONCLUSION

This chapter explained the overall structure of the study. It explained background information, statement of the problem, objective and purpose of the study, theoretical grounding, methodology and significance of the study. It portrays the whole components and structures of the document in a summarized manner.

CHAPTER 2

LITERATURE REVIEW

2.1. INTRODUCTION

According to Creswell (2013:60) description, literature review is a process of providing a framework or benchmark for comparing the results with other findings. Similarly, Literature review is an integral part of the research process which involves going through the existing literature in order to acquaint the researcher with the available body of knowledge in the area of interest (Kumar 2011:31).

In this study, the purpose of the literature review is to explore the nature and effectiveness of pro poor health care financing programs in addressing the health care needs of the poor. This will equip the researcher with comprehensive knowledge about fee waiver scheme on the global situation that in turn would enable the researcher to compare and contrast with the situations in Ethiopia.

2.2. GLOBAL SITUATION OF ACCESS TO HEALTH CARE

Globally, 808 million people incurred catastrophic spending in 2010, which is equivalent to 12 % of the world's population (Adam et al 2017:5) and an estimated 97 million people were impoverished on health care at the 2011PPP$1.90 a day poverty line (WHO & World Bank 2017:11).

In response to this, the United Nations general assembly called on governments to "urgently and significantly scale up efforts to accelerate the transition towards Universal access to affordable and quality health care services" (WHO 2012). The goals of universal health coverage are to ensure that all people can access quality health services to safeguard all people from public health risks and to protect all people from impoverishment due to illness whether from out of pocket payments for health care or loss of income when a house hold member falls sick (Maeda, Araujo, cashin, Harris, Ikegami & Rei 2014:1).

The new World Health Organization/World Bank Universal Health Coverage framework requires countries to adequately track disadvantaged populations in terms of achieving equitable access, effective coverage, and financial risk protection within their own settings (Wolfe 2014:6). This global movement has motivated dozens of low and middle income countries to implement various programs that aim to achieve Universal Health Access (UHC). Ensuring universal access to affordable, quality health service will be an important contribution to ending extreme poverty by 2030 and boosting shared prosperity in low and middle income countries, where most of the world's poor live (Maeda et al 2014:1)

2.3. HEALTH CARE FINANCING IN DEVELOPING COUNTRIES

Even though, Universal Health Coverage offers great opportunities for reducing poverty and securing the health care needs of a country's lower income groups, how to mobilize and manage financial resources for health systems are crucial problems of the developing countries (kai 2015:16). Against a backdrop of severely under funded health systems, government of these societies including several in Sub Saharan Africa are faced with a dilemma as to the best option of getting their citizenry access to equitable and affordable health care services (Manortey 2013:33).

In adequate financial protection and lack of accessibility have been documented in many health equity studies as factors influencing use of health care services by the poor and rural population (Mwandira 2012:15). Attempts to use the user fees system to finance health care delivery seems in many cases have presented several barriers to access, causing many of the people to change their health care service seeking behaviors to the detriment of their lives (Manortey 2013:33) and they spend a greater proportion of their income on treatment than non-poor households do (Mwandira 2012:15).

2.4 PRO POOR HEALTH CARE PROGRAMS AND THEIR EFFECTIVENESS

To exploit the potential of Universal Health Coverage (UHC), each country needs to develop an adaptive health system with solid institutional foundations and governance, leaders with the vision to take advantage of these opportunities (Maeda et al 2014:54). UHC programs should focus on increasing coverage and decreasing economic barriers

to access amongst the most disadvantaged groups by deliberate adoption and scale up of strategies that aimed at reaching the poorest first (Rodney & Hill 2014:4).

At policy level, various suggestions are provided in order to improve the exemption and waiver system. Exemptions and waiver systems are stipulated in the legislation that they should be implemented at district level (Munishi 2010:71). Districts need to institutionalize the process of identifying the eligible poor prior to illness and village leaders should be empowered to identify the poor based on clearly defined eligibility criteria. It is evident that communities know each other better and this might make the identification process easy (Maluka 2013:7).

Health policy analysts and policy makers must be realistic when working within socio economic constraints. The concern should be mainly over how well the poorest within a country fare and whether the distribution of health care in countries conforms to egalitarian ideals (Maluka 2013:6). The fact that many targeted health insurance schemes were implemented a few years ago across Sub Saharan Africa, the robust scientific evidences on their effectiveness is limited and can be difficult to interpret (Bonfrer 2015:174-75). Most findings indicate that the pro poor exemption and waiver mechanisms are in effective in implementation that they are administratively challenging and therefore costly (USAID 2017:35; Maluka 2013:6).

Lack of knowledge about the purpose and eligibility criteria among health care providers **(**Kuwawenaruwa, Baraka, Ramsey, Bellows, Manzi& Borg 2015:2), Poor policy design, lack of adequate involvement of the local communities, intended beneficiaries and service givers, failure of the central governments to define standardized eligibility criteria for waivers and lack of monitoring and valuation particularly at the lower levels are the major causes for the in effectiveness of the programs (Maluka 2013:6; Wolfe 2014:6; Witter, Garshong, & Ridde 2013:6).

Furthermore, funding delays of (said to average 5 months) which cause facilities to withhold free services (Witter et al 2013:4), low reimbursement rates (Wolfe 2014:6), and limited technical support exacerbate the problems and contribute to the implementation problems of the pro poor exemption policy at lower levels (Maluka 2013:6; Wolfe 2014:6).

The supply side barriers, such as the lack of availability of critical medical supplies and drugs at the point of need (Witter et al 2013:6), lack of availability of skilled manpower, and lack of Incentive to health facility committees and board members (Maluka 2013:6) were raised as considerable concerns. Distance to facilities, socio cultural barriers, differences in physical access facilities which means that better off women are able to benefit disproportionately, and skewness of facilities towards the urban areas were also mentioned as major barriers that inhibited health care access (Witter et al 2013:6).

Thus, these findings challenge the underlying assumptions of these programs are pro poor policy that foster equity in access to care (Akazili, Welaga, Bawah, Achana, Oduro, woonor-Williams, Williams, Aikins, & Phillips 2014:6). The wider concerns about raising quality of care and ensuring that all supply-side and demand-side elements are in place to make the policy effective will take a longer term and bigger commitment (Witter et al 2013:9).

2.5 FEE WAIVER SCHEME IN ETHIOPIA

Ethiopia institutionalized mechanisms for providing services to the poor free of charge through a fee waiver scheme (FMOH 2014:31). The fee waiver scheme is one component of the country's health care financing reform that ensures people pay for health services according to their ability to pay, protecting the "poorest of the poor" (households or individuals who fall in the category of the last margin of the under poverty level by the administration of their province) from the financial barriers to seeking health services by covering the cost of fee waivers by an appropriate third party (AACAHB 2009:39-40, FMOH 2014:31).

As per health services delivery and administration proclamation and regulation, the woreda administration is responsible for fully compensating service providers for the revenue they forgo by providing health care services to fee waived beneficiaries free of charge. This is based on the principles of no service is "for free" and is intended to link the body issuing the fee waiver certificate with the payment (USAID 2014:47-50).

Since the establishment of this scheme, there have been improvements in government allocation for fee waivers to facilitate access. The total subsidy for the poor has reached

more than 20 million Birr (870,000 $) so far and the number of fee waiver beneficiaries has also reached 2 million (FMOH 2016:50-51). However, according to FMOH (2014:31), poor health care financing is still one of the major challenges for the health system in the country. Despite the fact that the government allocation for fee waivers to facilitate health care access for the poor has significant improvements over the last few years, the program still serves less than 10% of the total population that lives below the poverty line in the country (FMOH 2016:50-51).

Similarly, a study conducted to assess the willingness to pay for community based health insurance shows that 59% of the households with any type of illness are facing a difficult problem in finding the money for medical expense and 65% of them are making money for health care by selling capital assets, which shows the existence of medical impoverishment (Adane, Measho & Mezgebu 2014:5).

In general, the fee waiver scheme is characterized by inappropriate targeting of the poor and incomplete coverage of health care services that the responsible government body should advocate fair and equitable selection of waiver beneficiaries, health facilities to submit all expenses claiming for reimbursement and the woreda finance offices should reimburse expenses incurred by facilities on timely manner (USAID 2014:50).

2.6 CONCLUSION

In this chapter, the researcher has explored the impoverishment level at global, in developing countries and in the Ethiopia context. Besides, the countries' general health care financing programs and pro poor financing schemes were also assessed to see if they are addressing the health care needs of the poor society.

In general, most findings show that there are significant technical and financial limitations during the design, implementation and evaluation of the pro poor health care financing programs. Hence, the poor are facing difficulties in accessing health care at all levels.

Lack of involvement of the beneficiaries and the health care providers during the inception of the programs, shortage of supplies and drugs, shortage of skilled man power and lack of regular monitoring of the program were raised as the most prominent problems inhibiting the effectiveness of these programs.

CHAPTER 3

RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

The purpose of this chapter is to comprehensively describe and elaborate the design and methodological aspects used to evaluate the effectiveness of the fee waiver scheme and to develop proposed implementation framework to address the health care needs of the poor in Addis Ababa, Ethiopia. Research design, sampling procedure, data collection, data analysis and ethical considerations of the study are elaborated in this chapter.

3.2 RESEARCH DESIGN

According to Johnson and Christensen (2014:875), research design is “the outline, plan, or strategy that is used to answer research questions”. It should also indicate how the research setting is going to be arranged in order to yield the desired data with least possible contamination/error by intervening variables (Pandey 2015:107). Qualitative study entails the in-depth examination of the qualities, characteristics or properties of phenomenon to be understood or explained (Botma, et al 2010:182).

In this study, the researcher used qualitative research approach with exploratory, descriptive and case study designs to explore the effectiveness of the fee waiver scheme in addressing the health care needs of the poor in Addis Ababa. The researcher believed that the research questions and the intensions of this research are best explored and investigated with this design. It deeply examined the study participants’ perspective, knowledge, feelings and experiences about the program implementation and its impact.

3.2.1 Exploratory research design

According to Johnsen and Christensen (2014:855), exploratory design is “a bottom-up or theory-generation approach to research”. This bottom up approach emphasizes the formulation of theory or hypothesis by starting with particular data (Johnsen &Christensen 2014:63). Similarly, Polit and Beck (2012:18), also define research design

as “a design that begins with a phenomenon of interest, but rather than simply observing and describing it, it investigates the full nature of the phenomenon, the manner in which it is manifested and the other factors to which it is related”.

In this study, the feelings and experiences of the study participants were carefully tracked through an open ended interview guide that enabled the researcher to develop concrete meaning and concept after comprehensive observation and patterns formulation about the effectiveness of the fee waiver implementation process. The verbal and non-verbal responses and emotions of the participants towards the research questions were captured and explored through extensive investigation of the situations.

3.2.2 Descriptive research design

Descriptive design is a design that focuses on bringing the accurate description or picture of the situation in a visual way to the minds of the audiences (Johnsen & Christensen 2014:851). Similarly, Polit and Beck (2012:725) also describe it as a way of accurately portraying people’s characteristics or circumstances occurred on the field.

In this study, the situations, events, and emotions which were investigated through the exploratory approach on the field were well described and narrated in a way that readers could feel and see the ideal conditions that occurred during the data collection period. The nature of the interview guide was also a descriptive open ended type that motivated the participants to describe their feelings and experiences about the limitations and strengths of the fee waiver implementation.

3.2.3 Case study design

Case study design is “a qualitative design in which the researcher explores in depth a program, event, activity, process, one or more individuals” (Cresswell 2013:290). Likewise, Leedy and Ormrod (2010:271) also describe case study design as a method through which an in depth study is done for events or programs for a defined period of time. Case studies provide researchers with opportunities of having an intimate knowledge of a person’s condition, feelings, actions (past and present), intentions and environment (Polit &Beck 2010:271).

In this study, the researcher conducted an in depth investigation on the fee waiver scheme design, implementation process, and intensive assessment to explore the participants' opinion and perceptions on the scheme's effectiveness. Detail information was collected through various data collection approaches by dwelling with the study participants for lengthened period of time. Besides, to ensure the comprehensiveness of the data, the researcher purposively drawn the study participants from various levels and settings who have been, benefiting from, implementing and coordinating the fee waiver scheme process. Hence, perceptions and experiences of the study participants were triangulated and come up with pertinent findings.

Even though it has been long time since the scheme is implemented, little is known about its effectiveness especially in exploring the determinant factors that positively or negatively affect the effectiveness of fee waiver scheme. Hence, this study filled the limitations of resources and evidences through in depth investigation especially on how well the policy was designed, the process of screening eligible beneficiaries, the scope of the services covered satisfaction of the beneficiaries and the extent of the financial protection made to the beneficiaries.

3.3 RESEARCH METHOD

Johnson and Christensen (2014:875) describe research method as "the overall research design and strategy". This study employed qualitative research method to evaluate the implementation process and effectiveness of the fee waiver scheme in improving health care access by the poor population in Addis Ababa. Likewise, according to Creswell (2013:295), research method "involves the forms of data collection, analysis and interpretation that researchers propose for their studies".

The researcher described the research method, procedures and strategies applied in this study in two phases as follows.

3.3.1 Phase One

Phase one of this study was aiming to evaluate the effectiveness of the fee waiver scheme in addressing the health care needs of the poor in Addis Ababa. Hence, the

methodological procedures used to address the first objective of this study are described by the researcher as follows.

3.3.1.1 Setting

According to Taylor, Bogdan and Devault (2016:32), research setting is "*one in which the observer obtains easy access, establishes immediate rapport with informants, and gather data directly related to the research interests*". Similarly, it is the physical location and conditions in which data collection takes place in a study (Polit & Beck 2012:743). The research settings for this study were health facilities and responsible government offices at Addis Ababa city administration and at woreda levels. As the researcher is well familiar with the context and working conditions of the region, it has helped him a lot in understanding the emotions and feelings of the participants.

Addis Ababa is the largest as well as the dominant political, economic, cultural and historical city of the country established in 1887 by emperor Menilik II. It is the capital of the federal government of Ethiopia and a chartered city categorized in to 10 Sub-Cities and 116 Woredas. Based on the country population and household census (2007), the total population of Addis Ababa is estimated to be 2.7 million of which (47.7%) are males and (52.3%) are females.

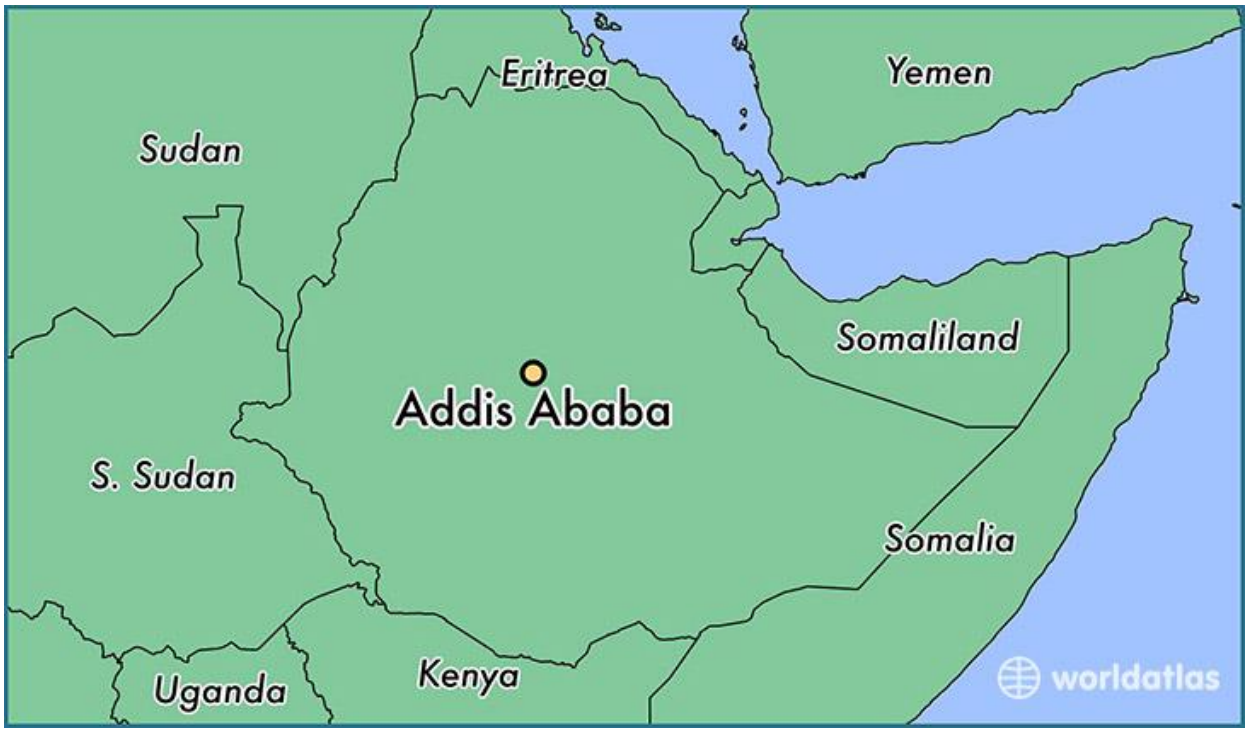

Figure 3.1 Map of Ethiopia and neighboring countries with Addis Ababa, at the center

3.3.1.2 Population

Johnson and Christensen (2014:869) define population as "the large group to which a researcher wants to generalize the sample results". Likewise, Polit and Beck (2012:738) also define a population as an aggregate of all individuals or objects to be studied with some common defining characteristics. In this study, fee waiver beneficiaries and the implementers of this FWS participated in the implementation of the program in Ethiopia are the populations from which accessible populations are extracted.

Accessible population: It is "the group of research participants who are available to the researcher for participation in research" (Jonson & Christensen 2014:401). Hence, fee waiver beneficiaries and individuals directly participated in the implementation of the program in Addis Ababa city administration are the accessible population for this study. The study populations were selected using the following inclusion and exclusion criteria.

Inclusion and exclusion criteria: "Prior to sampling, it is advisable to determine those especially extreme characteristics and properties that may distort results and /or affect

the homogeneity of the sample" (Boncz 2015:29). In this study, the researcher has identified and listed the inclusion and exclusion criteria as follows:

Inclusion criteria:

- Community representatives participated in the beneficiaries' selection process for at least one year.
- Fee waiver scheme beneficiaries who have been using the service for at least one year and are above 18 years old.
- Health care professionals and Health extension workers with at least one-year experience in implementing the program
- Health office, labor and social affairs office, women and children affairs office managers at region, sub city and woreda levels who have been directly managing the program for at least one year.

Exclusion criteria:

- Fee waiver scheme beneficiaries who are mentally retarded or disabled
- Fee Waiver Beneficiaries below 18 years old
- Professionals with less than one-year experience in implementing the program.

3.3.1.3 Sampling

According to Johnson and Christensen (2014:876), sampling is "the process of drawing a sample from a population". In qualitative studies, sample selection is driven to a great extent by conceptual requirements rather than by a desire for representativeness (Polit &Beck 2012:516). In this study, the researcher used non-probability sampling with purposive and convenience methods to sample the study population.

Non probability sampling: is a sampling procedure which does not afford any basis for estimating the probability that each item in the population has of being included in the sample (Polit & Beck 2012:735). In this study, the researcher selected the study participants via non probability sampling procedures so that participants who have rich information about the subject could be involved in the study. This means the key informants and FGD participants are selected deliberately by the researcher.

Purposive sampling: is a sampling procedure through which researchers select known study subjects or settings using their own preset reasons mostly due to searching for richness of information (Boncz 2015:29).

To ensure the richness of the information required, woredas with the highest number of fee waiver beneficiaries in the previous two years were selected purposively. Similarly, with the aim of getting rich information and discover multiple realities about the scheme, a purposive selection of different participant categories was performed. The participants' category includes: health care professionals who provided fee waiver service, community representatives participated in the beneficiaries' selection process and woreda administration professional who have managed the fee waiver service.

Convenience sampling: Convenience sampling sometimes called accidental sampling is a sampling process when researchers rely on easily available study participants (Boncz 2015:29). Similarly, Johnson and Christensen (2014: 362) also describe convenience sampling as process in which researchers include in their sample people who are easily available or willing to participate on the study.

Hence, in this study, the researcher used convenience sampling process to select the fee waiver beneficiaries who visited the health center during the data collection period. However, before engaging them for the interview, the researcher confirmed whether the beneficiaries full fill the inclusion criteria listed above.

3.3.1.3.1 Sample

According to Johnson and Christensen (2014:876), a sample is “a set of elements or cases taken from a larger population”. It is a subset of a population that shares the same characteristics and attributes to be included in the study (Polit &Beck 2012:742).

Qualitative researchers are more concerned on the quality of sample they select than on the magnitude of the sample. Though the sample size in qualitative research may be limited in size, the intentional selection of participants with rich information and the in-depth exploring of the reality of the context until new idea is no more generated is an added benefit.

Therefore, in this study, sixteen in-depth interviews and three FGDs were conducted with the study participants. The in-depth interview was done with fee waiver beneficiaries (n=2), health facility social work lead (n=1), health facility card room expert (n=1), health facility managers (n=3), woreda health office managers (n=5), regional health bureau coordinators (n=2), wored labour and social affairs expert (n=1) and community volunteer (n=1). similarly, the three FGDs were conducted with fee waiver beneficiaries (FGD1, n=7 and FGD2, n=6) and with Health extension workers (1FGD, n=7).

3.3.1.4 Data Collection

According to Polit and Beck (2012: 744), data collection is an approach to collecting data from participants through various mechanisms such as self-report, observation, FGD or through in depth interviews. The data collection period took place from 2nd January 2018 until 16th February 2018 on the selected study settings. The data collection instruments used for this study include a semi structured interview guide with open ended questions, audio recording instrument for recording the FGD and in depth interviews and a field note pad to take notes through observation that could not be captured by the audio recorder. The data collection was done by the researcher himself and one research assistant who are well experienced and equipped in qualitative data collection skills.

3.3.1.4.1 Data collection approach and method

According to Johnson and Christensen (2014:313), methods of data collection is a technique for physically obtaining data from study participants to be analyzed later on in a research study. In this study, the researcher collected data through key informant interview, focus group discussions and through observations. The data collectors have noted the non-verbal movements, signs and reflections of the study participants during the data collection process. These recorded notes were later on used to substantiate the meanings and concepts of the finding during the writ up of the study.

Key Informant Interview (KII): According to Polit and Beck (2012:732), key formant interview is a process of interviewing a knowledgeable person about the subject matter of the research interest and who is willing to share the information and his/her insights with the researcher. It is a process in which participants talk in depth about the topic under investigation without the researcher's use of predetermined, focused, short answer questions. Given (2008:422-423) describe this as a semi structured interview because the researcher retains some control over the direction and content to be discussed, yet the key informants are free to elaborate the interview in new but related direction.

In this study, the researcher used an open ended interview guide through non-directive style of interviewing to express their experiences and opinions about the design, implementation process and effectiveness of the scheme in achieving its intended objectives. In some instances, directive styles of questioning were also used when the researcher required to probe the participants so that they can give more clarification and explanation on the subject. This KII was used as a data collection approach to explore the opinions, feelings and the experiences of the waiver beneficiaries, health care providers, card room staffs and health managers at different levels.

Focus Group Discussion(FGD): Is a discussion with a small group of people usually 6 to 12 participants who are purposively selected when researchers believe they can provide the rich information about the study subject (Jonson & Christensen 2014:326). It is a carefully planned discussion process with small homogeneous groups on written set

of questions that take advantages of group dynamics for accessing rich information in an economical manner (Polit & Beck 2012:537).

This method was used as a good opportunity to collect multi-dimensional realities and experiences from different fee waiver beneficiaries who have visited the health facilities and health extension workers during the data collection period. The FGDs were conducted with fee waiver beneficiaries at health facilities and with health extension workers to explore their opinions, experiences and feelings about the design, implementation and effectiveness of the fee waiver system in the selected woredas and facilities. The researcher believes these FGDs have played significant role in generating new ideas and experiences through the information recall as a result of the group dynamics. The researcher was directly involved in this data collection process which benefited him to internalize the feelings and experiences of the study participants during the analysis process.

3.3.1.4.2 Development and testing of the data collection instrument

Interview guide for both data collection techniques (KII and FGD) was developed in English and translated in to Amharic by an experienced language professional. then, it was translated back in to English again to maintain its consistency**.** The interview guide was designed based on the program theory (logic model) of the fee waiver scheme that was prepared by the researcher after reviewing the existing documents and manuals of the program.

To ensure whether the questions were clearly understood and able to answer the questions of the study, the interview instruments were piloted on two selected health facilities before starting the actual data collection process. As a result, the researcher was able to revise and modify the instruments based on the findings from the pilot study. The researcher particularly improved the interview guide questions in a way that can be more focused and in-depth. Besides, few probing questions were also included after the pilot.

3.3.1.4.3 Characteristics of the data collection instrument

The data collection instruments used for this study includes a semi structured interview guide with open ended questions. The main components of the questions were focusing on exploring the opinions, experience and feelings of the participants based on the program theory of the fee waiver scheme. Besides, the tool also includes research question that could help explore their perceptions on the effectiveness of the scheme in addressing its intended objectives and their suggestions on what need to be changed and improved in terms of policies, implementation and infrastructures.

3.3.1.5 Data analysis and management

This study employed qualitative data analysis and management technique to evaluate the implementation and effectiveness of the fee waiver scheme. According to Creswell (2013:234), “Qualitative data analysis mainly uses bottom up approach that creates patterns, themes and categories by organizing the raw data in to increasingly more abstract units of information”. Hence, the researcher this bottom up approach that the individual opinions and ideas were organized, synthesized at various stages and patterns and themes that summarize the whole concept of the study were developed and narrated later on.

The researcher employed Atlas ti version 7.5, qualitative data analysis software, to analyze the findings. This qualitative data analysis software is a powerful workbench for qualitative analysis of large bodies of textual, graphical, audio and video data (ATLAS ti user guide and reference 2013:9). The researcher gave full attention to the meaning of the participants’ interpretation and synthesized in to meaningful concepts that represent the study population and study contexts.

The researcher first translated and transcribed the FGD and KII data (primary documents) and entered them in to the data base. These primary documents were read extensively to internalize and deeply understand the meaning and sense of the responses from the study participants. Then, the researcher started disassembling the

primary documents in to codes. The codes are then brought in to broader concepts by formulating codes families, categories and themes. The researcher has been using networking and visualization tools within the atlas ti to see the interaction and relationship of the codes with codes, codes with categories and themes among each other.

As a result, six themes were formulated as key pillars of the finding that embraces the whole concept, theory, concerns and ideas of the study. This data analysis and the formulation of comprehensive themes stage has passed series of backs and forth routes. As the researcher keeps working on it, new ideas come to his mind and the codes, and categories got refined and changed which is of course the nature of the qualitative analysis process.

Finally, the narration and description of the research findings was done based on the formulated thematic areas. In addition to the data collected through FGD and KII, the researcher has also utilized the recorded field notes especially the non-verbal feelings of the participants to substantiate the description of the findings. Similarly, the researcher has been also taking memo using the Atlas ti features during the data analysis process which was later integrated in to the narration of the findings.

3.3.2 Phase Two

The purpose of this Phase was to address the second objective of this study; i.e. develop and propose fee waiver implementation framework based on the findings from the first phase. This Implementation framework consists of six strategic objectives and more than 27 core interventions. Preliminary implementation framework was initially drafted by the researcher based on the findings from phase one.

Then, a delphi technique was employed to validate the strategic objectives and core interventions. The researcher developed structured self-administered checklist along with validation criteria and sent to experienced experts for validation using selected criteria. These experts are senior directors, managers and coordinators who have been managing and coordinating the fee waiver implementation process in various levels and settings. Finally, the validation findings were analyzed, described and proposed as FWS

implementation framework. The methodological procedures and steps employed during this phase are described as follows.

3.3.2.1 Setting

As described in the first phase very well, it is the situations, setup and conditions where data collection takes place. Hence, woreda health offices, regional health bureaus, federal ministry of health and nongovernmental organizations closely working on this area and were based in Addis Ababa city were the settings for phase two.

3.3.2.2 Population

In this study, government sectors and partners participated in the implementation and management of the fee waiver scheme in Ethiopia were the populations from which accessible populations were extracted.

Accessible population: staffs who are directly engaged in the coordination and management for implementation of the program in Addis Ababa city administration are the accessible population for this study. These coordinators and managers are extracted from government sectors at regional and federal level and from implementing partners at the city.

3.3.2.3 Sampling

The researcher employed purposive non-probability sampling methods to sample the study population in this phase. Program directors, coordinators and implementers who had in-depth knowledge and experience on the fee waiver implementation were selected to validate the preliminary implementation framework. A total of seven experts were purposively selected from ministry of health (2), regional health bureau (2), woreda health office (2) and Nongovernmental organization (1) working on this area.

3.3.2.4 Data Collection

The researcher developed a self-administered checklist as a data collection tool for this phase. The checklist contained the preliminary strategic objectives and the core interventions of the implementation framework along with validation criteria labeled with five points likert scale. The validation criteria and their points include: Very High (5), High (4), Medium (3), Low (2), and Very Low (1).

Then, the researcher sent these checklist and criteria to the experts via their email along with consent forms and executive summary of the findings from phase one. Experts were told to send back the filled checklist and the signed consent form within two days.

3.3.2.5. Data analysis and management

First, the researcher checked the completeness of the checklists and then he researcher used a simple MS excel to calculate the mean of the scores given by the experts. The strategic objectives and core interventions were initially scored out of 75% and 125% respectively when every expert's score were added. Similarly, the total score of each criterion for every strategic objective or interventions were 25%. Finally, all experts' score for each strategic objective, core intervention against all criteria were added in their respective cells and converted in to 100% for easily understanding and interpretations. Hence, the numeric score results and the qualitative opinions of the experts were displayed and described accordingly.

3.4 ETHICAL CONSIDERATIONS

According to Jonson and Christensen (2014:192) description, considerations of research ethics is " a necessary part of the development and implementation of any research study that understanding of the ethical principles assists a researcher in preventing abuses that could occur and helps delineate his/her responsibilities as an investigator". The researcher and the data collector had an experience and were familiar with

principles of research ethics as they have been engaged in various similar researches. Besides, they were reminded about the principles before they started data collection.

Furthermore, in order to respect the rights of the study participants and institutions where the research was carried out the research proposal were reviewed and approved by responsible bodies before starting the study. Hence, the researcher has obtained an ethical clearance from the Higher Degrees Committee of the department of Health Studies at UNISA and a letter of approval and cooperation from Addis Ababa regional Health Bureau ethical committee to conduct the study. The researcher has considered the following domain specific ethical issues during the study period:

Informed consent: This refers to "agreeing to participate in a study after being informed its purpose, procedures, risks, benefits, alternative procedures and limits of the confidentiality" (Jonson & Christensen 2014:201). In this study, after the researcher has explained the overall purpose of the research, he provided them with written consent form to voluntarily decide their decisions.

Respect for Human Dignity: According to the description of Polit and Beck (2012:154), respect for human dignity includes the responsibility the researcher to provide study participants with full information on the research and the right of the participant to refuse participation. Hence, their participation was fully voluntarily. Besides, the researcher has also told them that they have the right to withdraw from the research at any time with or without informing the researcher.

Confidentiality: Refers to "an agreement with the research investigator about what can be done with the information obtained about a research participant" (Jonson &Christensen 2014:212). The researcher has informed the participants that the information obtained will be kept in a safe place only accessible to the researcher, and will be secured from any type of disclosure including from the researcher. Hence, participants' information is labeled by codes and is secured in a private place that no one could access it.

Beneficence: is acting to maximize the benefit of others (Johnson &Christensen 2014:2010). In this research, the researcher and data collectors have told the

participants that the study will contribute for the future development of policies which could improve health care access by the poor society.

Non maleficence: according to Johnson and Christensen (2014:201), this “refers to doing no harm to others”. Hence, there was no any harm for the participants during the process of the study.

Justice: This refers to the right of participants to be treated fairly as well as their right to have privacy (Polit & Beck 2012:155). The researcher has treated all participants fairly and equally and the privacy of participants has been maintained throughout the whole research process.

3.5 MEASURE OF ENSURING TRUSTWORTHINESS

Trustworthiness: “It is the degrees of confidence qualitative researchers have in their data, assessed using the criteria of credibility, dependability, conformability and authenticity” (Polit & Beck 2012:745). In this study, the trustworthiness of the research is maintained as the researcher has been doing the following practices.

Credibility: refers to the confidence in the truth of the data and its interpretations (Polit &Beck 2012:585). The truth of the research starts from the data collection process. In this study, data collection was conducted carefully and wisely by the researcher himself and experienced research assistant using piloted and refined interview guides. These data collectors stayed in the field for prolonged time which help the researcher to have in depth understanding of the situations under study and to the study environment. Hence, the researcher has synthesized the real situations, established broader concepts and explicitly narrated in a way that could reflect the truth on the ground. This is also described in Creswell (2013: 251) as the more exposure the researcher had to the study environment and the study participants, the more credible the research output becomes.

Besides, the researcher used various data sources that range from beneficiaries to implementers and managers through FGD and KII which enabled the researcher to triangulate the data and ensured that the established themes are based on evidences. Similarly, as mentioned in Polit and Beck (2012:175) that the research method also

contributes for the credibility of the study, the researcher employed purposive sampling method and selected groups and individuals who have rich experiences and knowledge on the subject matter that contributed for the enhanced credibility of the findings.

Members checking: According to Jonson and Christensen (2014:414), member checking is the process of getting confirmation on the narrated finding from the study participants. The researcher has shown the report of the findings to some of the study participants which they also explained their agreement that their concerns are exactly stated on the report.

Authenticity: Refers to the extent to which researchers fairly and faithfully show a range of realities (Polit &Beck 2012: 585). The report of this study finding conveys the real tones, languages, feelings and emotions of the participants on the field. The nonverbal languages that have been noted during the data collection have also contributed for the explanation of the real situation at the ground.

Confirm ability: Refers to "objectivity that is the potential for congruence between two or more independent people about the data's accuracy, relevance or meaning" (Polit & Beck 2012:585). The researcher has gone through audit trial process to make sure that the process of translation, coding, theme formations and interpretations were not influenced by the researcher's perspective. Once the researcher has gone through this all steps, the researcher invited the research assistant to see the whole process and confirmed that the process was done based on what was found on the field.

Dependability: "Refers to evidence that is in a consistent and stable pattern over time" (Polit & Beck 2012:175). The researcher spent significant time period with the data and had an in depth understanding of the concepts and meanings of every phrases. To ensure the consistency and stability of the finding, the researcher have compared the raw data with the established codes, code with their code definitions and checked the patterns of the codes when forming categories.

3.6 CONCLUSION

This chapter briefly discussed about the design and methodology of the study. Qualitative research approach supported with exploratory, descriptive and case study designs were employed to evaluate the effectiveness of fee waiver scheme in improving the health care access to the indigents in Addis Ababa city. The researcher used purposive and convenience sampling methods to sample the study population and study sites with the aim of ensuring the richness of the information required.

Hence, health facilities and woredas with the highest fee waiver beneficiaries in the last two years and staffs of these institutions with at least one-year experience on the program were selected purposively. Similarly, fee waiver beneficiaries who came to the health facilities during the data collection time who have been using the service for at last one year were selected using convenience sampling method. Focus group discussions and key informant interview types of qualitative data collection techniques were applied to collect the data from the study participants through experienced and well equipped data collectors.

Finally, the researcher employed qualitative data analysis procedures and used Atlas ti version 7.5, a Computer Assisted Qualitative Data Analysis Software (CAQDAS), to analyze the study findings. The researcher used bottom up approach and come up with concepts and themes that could represent the whole meaning of the research.

Hence, six themes were developed and used as an input for the development of the implementation framework. Fee waiver implementation framework was designed by the researcher and validated by selected experts later on.

CHAPTER 4

ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1 PHASE ONE: EVALUATION OF THE FEE WAIVER SCHEME EFFECTIVENESS

4.1.1 Introduction

This chapter generally presented the real situations, perceptions, experiences and conditions of the study participants based on the directions of the interview guides. Qualitative data management and analysis approach was used to manage the research findings. The researcher collected data from 2nd January 2018- 16th February 2018 in health centers, Hospitals, woreda health office, woreda labor and social affairs office and Regional health bureau. Semi structured interview guide was prepared and used for the data collection from the study populations.

The researcher used purposive sampling to select the study participants. Beneficiaries who have been utilizing the fee waiver services at least for one year were included in the study. Similarly, implementers who had at least one-year experience on fee waiver implementation were also selected. These implementers refer to people who were directly working on the areas of fee waiver scheme at different levels and settings. These include: Health care providers, health facility medical directors, health offices and bureaus coordinators, health facility social workers, health facility card room experts, health extension workers, and labor and social affairs office experts.

Sixteen KII and three FGDs were conducted during the data collection period. Two of the FGDs were conducted with fee waiver beneficiaries and the remaining was done with health extension workers. Similarly, the Key Informants Interviews were done with fee waiver beneficiaries, health facility medical directors, woreda health office heads and regional health bureau coordinators. Data saturation was the reason for limiting the number of FGDs and KII to these sizes.

During the data collection process, the researcher has been updating the interview guide to embrace the newly emerging ideas or concepts from the study populations. Besides,

field notes were taken during the FGDs and KII. Hence, issues that were not recorded with the sound recorder were tracked and incorporated.

Then, the researcher transcribed the interviews in a way that could show every aspect of the interview situations. Following the transcription process, the researcher and his assistant translated it in to English and ensured the consistency of the translation through repeatedly reviewing the meanings of the interviews. Besides, the researcher conducted the cleaning process rigorously.

4.1.2 Logic Model of Fee Waiver Scheme

Based on the existing documents, guidelines and manuals, the researcher created program theory (logic model) that shows the implementation and result pathway of the scheme. The researcher developed this program theory with consultation of the program owners, Addis Ababa city administration health bureau staffs. Hence, the researcher used this program theory as a reference for the evaluation of the scheme. Interview guides were prepared based on the components of this program theory.

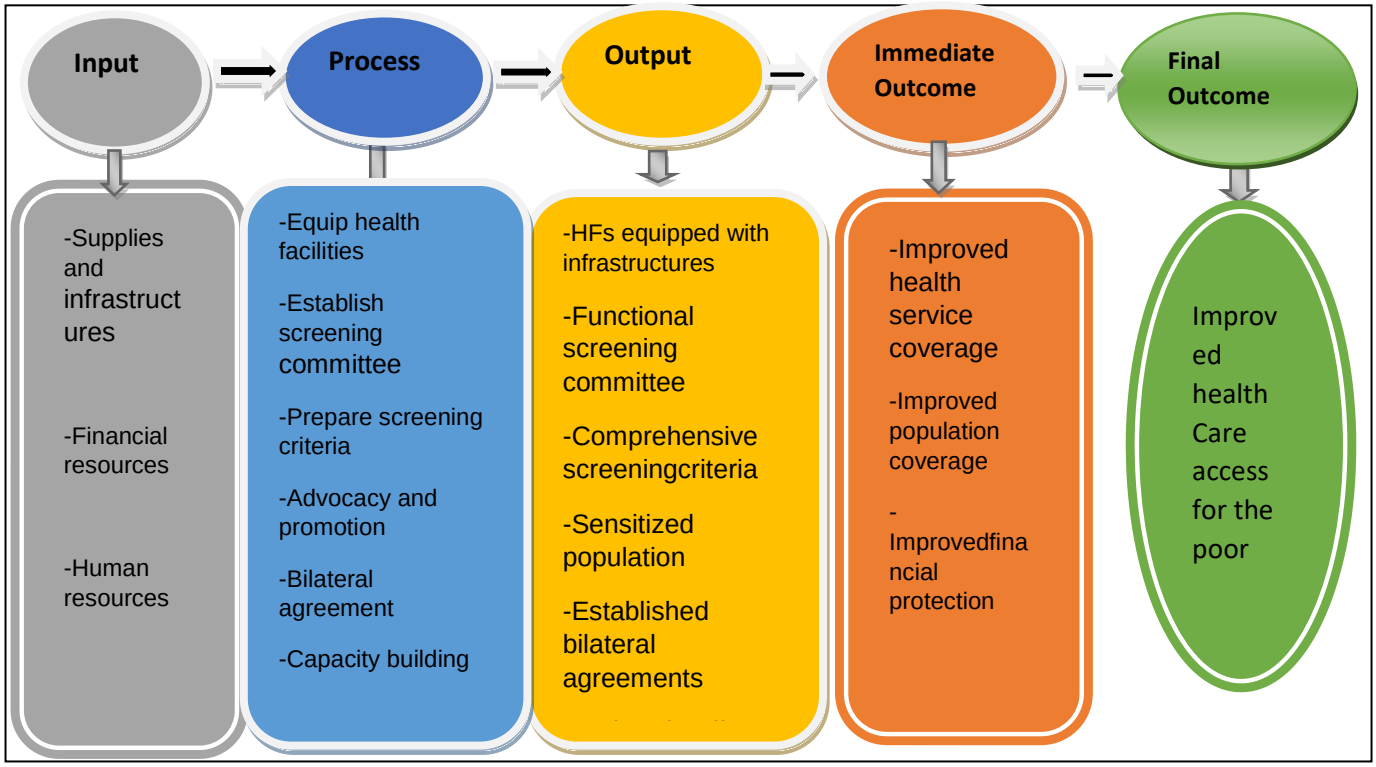

Figure 4.1 Logic model of fee waiver scheme in Addis Ababa city administration

4.1.3 Research results

4.1.3.1 Study participants' Socio demographic characteristics

Table 4.1 Characteristics of the study population

Sub City	Office /facility	Type of data collection and nature of participants
Arada	Woreda 3 Health office	Key Informant Interview
Arada	Woreda 4 labor and social affairs office	Key Informant Interview
Arada	Woreda 4 Health office	Key Informant Interview
Arada	Woreda 4 Community	Key Informant Interview
Arada	Minilik II Hospital	Key Informant Interview
Arada	Minilik II Hospital	Key Informant Interview
Arada	Minilik II Hospital	Key Informant Interview
Arada	Minilik II Hospital	Key Informant Interview
Kolfe keranyo	Woreda 13 health office	Key Informant Interview
Addis ketema	Addis Raey Health center	Key Informant Interview
Addis ketema	Woreda 7 health office	Key Informant Interview
Addis ketema	Addis Raey Health center	FGD with Beneficiaries (I)
Nifas Silk	Woreda 6 health office	Key Informant Interview
Nifas Silk	Woreda 6 health center,	Key Informant Interview
Nifas Silk	Woreda 6 health center ,	FGD with beneficiaries (I)
Nifas Silk	Woreda 6 health center	FGD with HEWS (II)
Kirkose	Meshalokia health center ,	Key Informant Interview
Bole	Addis Ababa regional health bureau	Key Informant Interview
Bole	Addis Ababa regional health bureau	Key Informant Interview

As depicted in the above table 4.1, a total of thirty-six study populations were participated in the study in FGDs and KII data collections processes. Sixteen KII and three FGDs

were held with beneficiaries and implementers of the fee waiver scheme implementation. The FGDs' participants ranges from six to seven members where the two FGDs comprised seven members each and the last FGD contained six members. The implementers were purposively selected from coordination offices/bureaus, service delivering health facilities and the beneficiaries were conveniently selected while they were visiting health facilities.

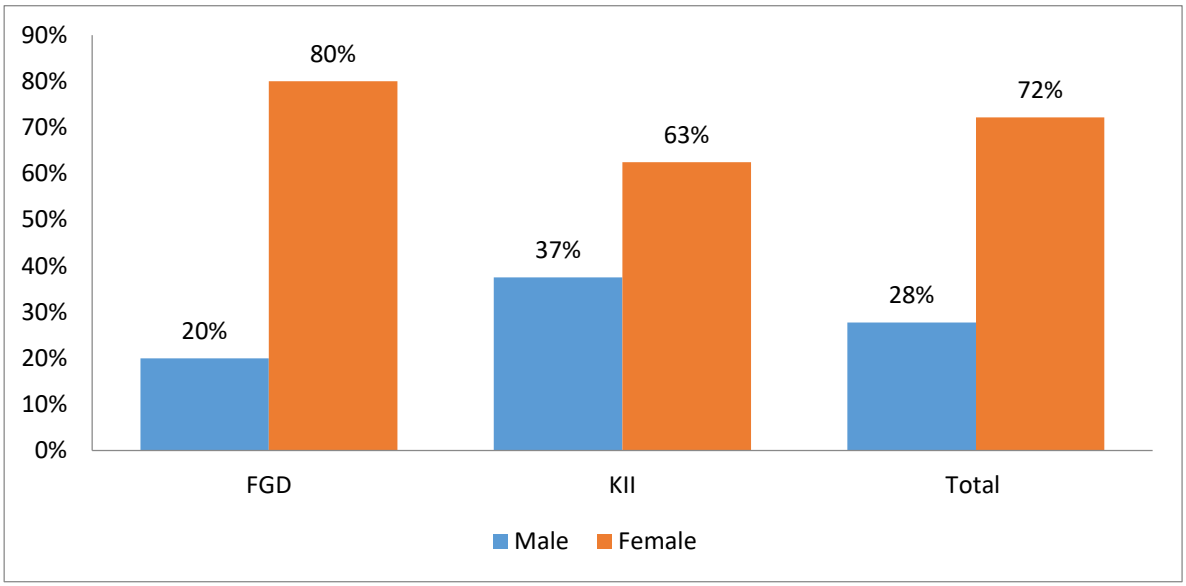

Figure 4.2 Sex composition of the study participants

The above figure (4.2) shows the sex composition of the study participants (n=36). Hence, the overall sex composition ratio for men and women was 28% and 72% respectively. When looking the composition of FGD Participants, it was 20% and 80% for men and women respectively. Whereas the composition of women in the KII was found to be 63% respectively.

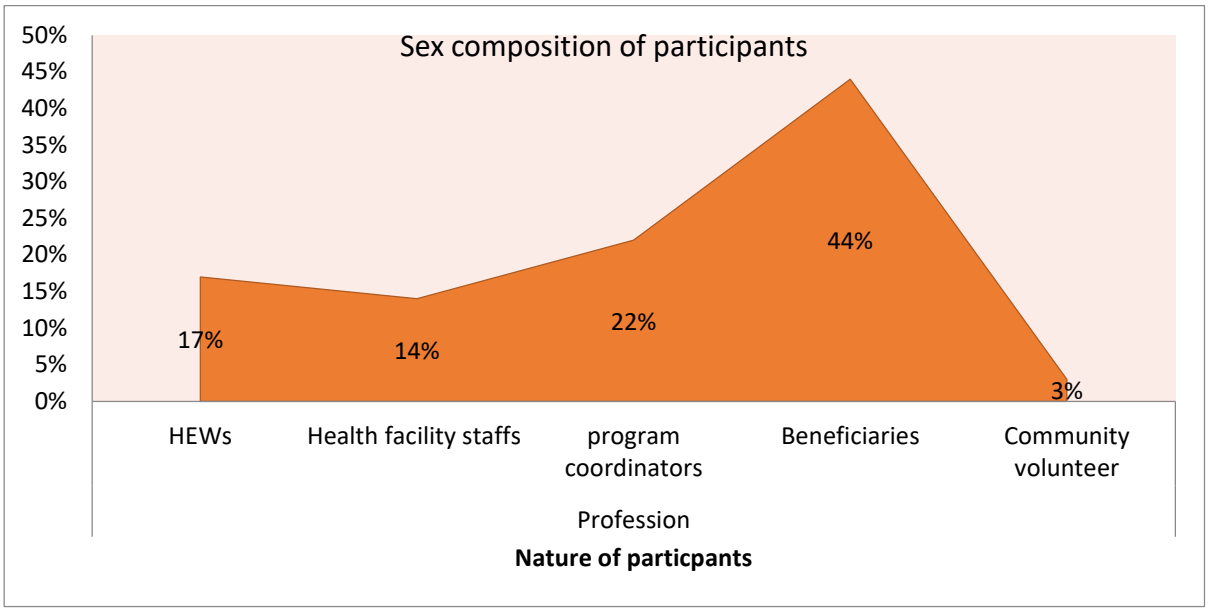

Figure 4.3 Study participants' composition in terms of roles.

The above figure (4.3) shows the study participants composition in terms of nature of roles. Accordingly, the fee waiver beneficiaries hold the highest portion 44% (n=16) followed by the program coordinators 22%(n=8). These program coordinators include staffs from regional health bureau, woreda health offices and woreda labor and social affairs offices. Similarly, the HEWs, health facility staffs and the community volunteers covers 17%, 14% and 3% respectively. However, when the participants were classified in to two major categories, i.e. Implementers and Beneficiaries, the composition was 56% and 44% respectively.

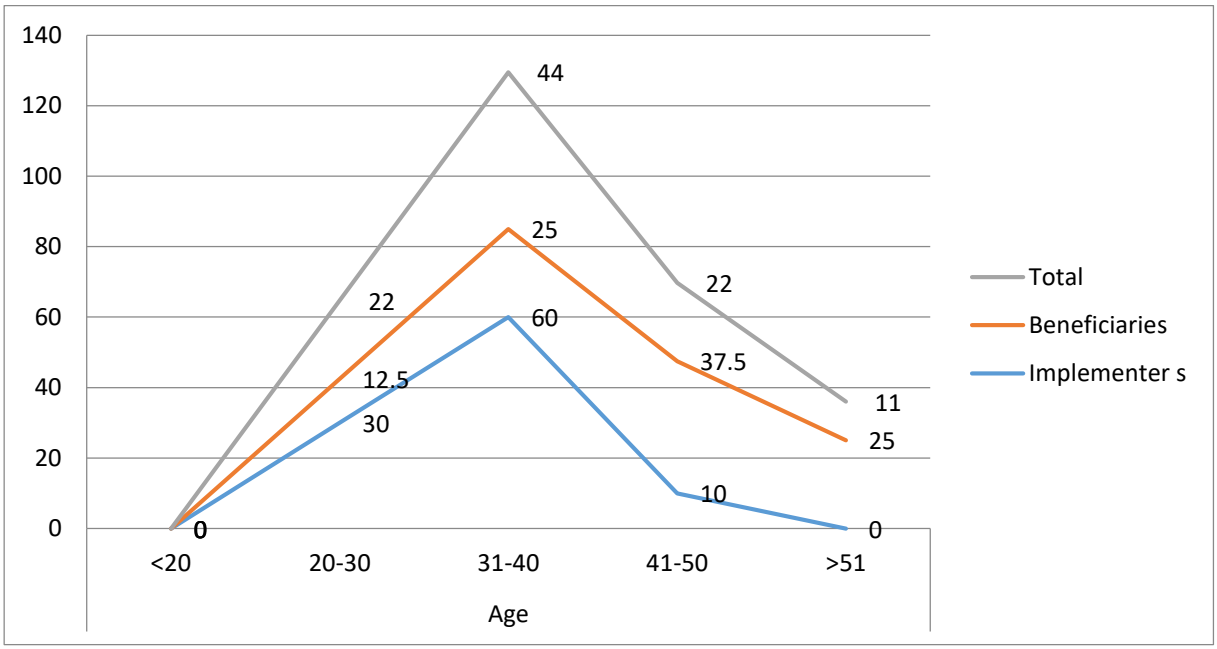

Figure 4.4 Age distribution of the beneficiaries and implementers

The above figure (4.4) shows the age distribution of the study participants (implementers and beneficiaries). Overall, 44% (n=16) of the study participants' age range falls under 31-40 years. Participants under the age group of 20-30 and 41-50 equally comprise 22% (n=8) each. Similarly, 11% (n=4) of the beneficiaries were older than 51 years old. This study finding also showed that all of the participants were older than 20 years old.

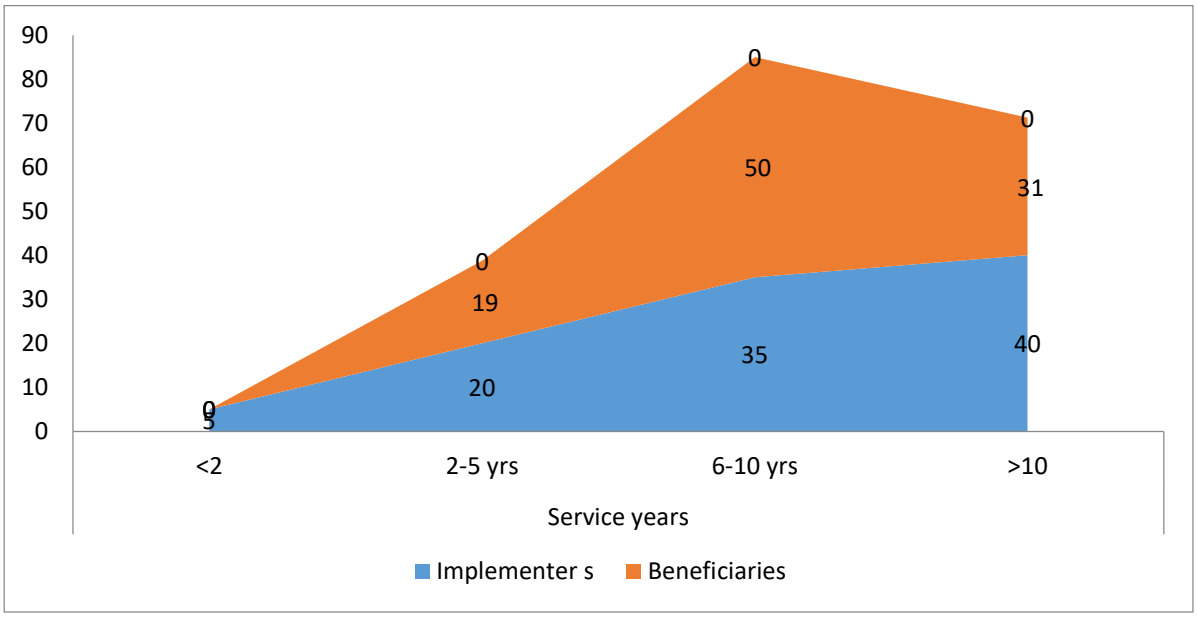

Figure 4.5 Services and membership years of the beneficiaries and implementers

The above figure (4.5) shows the service years of the implementers and the number of years that the beneficiaries have been members of the fee waiver scheme. 50%(n=8) of the fee waiver beneficiaries have been fee waiver users for around 6-10 years. Similarly, around 40%(n=8) of the implementers had work experience of more than 10 years. Only 5 % (n=1) of the implementers had work experience of less than two years.

4.1.3.2 Evaluation of fee waiver scheme implementation

According to the findings, the research is structured in to 6 themes, 19 Categories, 42 sub categories and 114 codes. The themes include: Ecological context, Population coverage, Health services coverage, financial protection, Performance management and Leadership. The summary of the six themes and the 19 categories is depicted in table as follows.

Table 4.2 Over all themes and categories summary

Themes	Categories
Ecological context	Ecological needs
	Ecological opportunities
	Ecological problems
Population coverage	Advocacy and Promotion
	Beneficiaries screening process
	Stakeholders engagement and management
Service coverage	Resources and infrastructures
	Staffs perspective
	Health service quality
	Stakeholders demand
Financial protection	The scheme meets its purpose
	Compromise basic needs
	Sacrifice health to take care of family
Performance management	Monitoring and Evaluation Framework
	Information management and documentation
	Performance monitoring and evaluation
Leadership and governance	Coordination and Management
	Lack of decision making
	Political ownership and commitment

4.1.3.2.1 Theme One: Ecological Context

The ecological context theme assessed the contextual factors that affect the fee waiver scheme implementation either positively or negatively. These factors include: background, beneficiaries, needs, existing resources and problems. The information related to the back ground of the fee waiver scheme and the beneficiaries was described in chapter one of this document. Hence, the researcher preferred to focus on the needs, opportunities and problems of the ecological contexts. Participants' quotations regarding the ecological context are presented in italics under each categories and subcategories.

Table 4.3 Theme one, categories and subcategories development structures

Themes	Categories	Sub categories
Ecological context	Ecological needs	Improved Population coverage
		Comprehensiveness of health services
		Ensured sustainable economic development
	Ecological opportunities	Existence of Public pharmacies
		Community based programs
		Organized community volunteers (Aderejajet)
		Health facilities governing boards
	Ecological problems	Delayed CBHI implementation
		Nature of the city

4.1.3.2.1.1 Ecological Needs

This category mainly assessed the overall demand of the population with respect to the fee waiver scheme implementation.

- ✓ *The need for free health care services*

According to the finding, most population demanded health services for free regardless of their economic statuses. This was due to the expensiveness of the existed health services that imposes difficulties even in peoples with relatively better economic status. Besides, the existence of too much economically poor population in the city has also caused the increased need for free health care service. Participants' direct verbatim were put in italics as follows.

> *"By the way, in Ethiopia, even those who are expected to have good economic status couldn't access the health care service very well, as it is becoming very expensive even for them" (FGD1-P2).*
>
> *"As Addis Ababa is the capital city for the country and the seat for African Union and many international organizations, its nature is complex which needs complex management approaches. Hundreds of migrant are entering in to the city from all areas of the region for various economic and social reasons" (KII-HB11).*

- ✓ *Demand for comprehensive services*

This study revealed that health facilities were not providing comprehensive services to the poor population. These facilities were not equipped with necessary inputs such as drugs, machines and skilled manpower. As a result, beneficiaries were forced either to go to private facilities or abstained from getting the services due to financial difficulties. Hence, the need for comprehensives services was among the particpants' priority demands. Woreda health office head (KII-HO11) described the need for advanced health facilities as:

"*It is better to make health centers equipped with materials and staffs and making the health care convenient and effective. It could be good if hematology and chemistry test are done a health center levels. As crowdedness increases, it creates problems of good governance. We are looking at it seriously. So, it is better to empower and strengthen the health centers for serving the community of the woreda*".

Similarly, another head of woreda health office (KII-HO3) supported the above statement as:

"*There should be strict follow up for the availability of inputs and service in the Health centers. "We said, these people are poor, so how do we say we are serving them properly without providing drugs to them? The biggest costly thing is I think drugs. And we are not availing them, it is contradicting".*

- ✓ *Ensure sustainable economic development*

This study discovered that there was also a need to transform the economic status of this poor society in the long run while serving them till they get transformed. Once these poor are economically transformed, the government contribution for the poor could be transferred for other developmental interventions. Heads of woreda health offices described this as:

"We need to work also on creating sustainable economic development for the poor so that the poor can contribute and be involved in the community based health insurances" (KII-HO33)*.*

"*We are also educating the poor not to remain poor, we are enforcing them to start works through cooperatives not be dependent on the governments"* (KII-HO55)*.*

4.1.3.2.1.2 *Ecological opportunities*

Ecological opportunities are types of existing resources or assets that could create enabling situations for the fee waiver scheme implementation. Based on the finding, key sub categories that describe these opportunities are listed as follows.

- ✓ *Existence of public pharmacies*

Existence of Kenema pharmacy, a public pharmacy, in the city is among the golden opportunities that need to be utilized. This public pharmacy was providing pharmaceutical service to the population with low cost. Zewditu hospital, which serves almost 700 patients a day has created partnership with this pharmacy and opened a mini pharmacy within the hospital compound to serve only for those paying patients. Meanwhile, the hospital pharmacy only served the fee waiver beneficiaries.

Hence, this was a good opportunity for the beneficiaries and for other health facilities to benchmark and adapt it in to their own setup. Regional program coordinator (KII-HB22) described this as:

> *"There are health facilities that have drug store that serve only for fee waiver beneficiaries. For example, Zewditu hospital doesn't sell drugs to paying patients during the day time. They have kenema pharmacy in the compound that sells to the paying patients. As kenema is also a government pharmacy, they are helping each other".*

- ✓ *Existence of community based programs*

- *Health Extension Program (HEP)*

The health extension program is a community based program through which the health extension workers provided preventive primary health services to the community through regular visiting of households. It was found that this program was playing a critical role in enhancing the implementation of the fee waiver scheme. The health extension workers are members of the community based screening committees that they were used as a good sources of information to trace the poor households in the community. The role of the HEWs and the program is explained as follows.

> *"In the group of the ketena or community screening members, health extension workers are involved. These health extension workers know every secret of the households. Even households with chronic diseases who don't want to disclose their health problems disclose to the health extension workers as they know them very well"* (KII-HO55)*.*

She continued:

> *"There are amazing people who are discovered by the health extension workers that seem forgotten with unbelievable life history which is miserable even to hear"* (KII-HO55)*.*
>
> *"The HEWs make round through house to house and they identify, prioritize the poor's together with the kebele people" (FGD1-P3).*

- *Primary Health Care Unit (PHCU) package*

This primary health care unit was also playing significant contribution for tracing and treating of poor patients who cannot visit health facilities due to financial problems. The importance of the PHCU is explained in KII as follows:

> *"Our woreda is one of the pilot woredas for Primary health care unit practice. So during the visit, our team is getting people that are sick at their home with simple diseases that can easily be treated. For example, recently we found 14 people that are poor and I convinced the committee and provided the certificates" (KII-FM11).*

He continued

> ***"**They carry their apparatus and some medications that can serve at community. For those that need detail investigation, they send them to the health center for further assessment and treatment. Even if they get patients that are not fee waiver beneficiaries, the medical director takes the risk and sign for their treatment, because we are bringing them from their home for treatment. So, we couldn't let them pay for the services" (KII-FM11).*

- *Community Based Health Insurance (CBHI)*

The Community based health insurance is now being piloted in ten woredas in the city. When this package is fully implemented, the fee waiver beneficiaries will be transferred to this CBHI scheme where their cost will be covered by the government as it is being done currently. According to the participants' reflection, most of the existing challenges

such as lack of drugs and biased screening issues will be solved when the CBHI starts. Quotations related to CBHI opportunities are described in italics as follows:

"Currently, we are piloting the program in ten woredas from each sub city. This program is expected to benefit the poor even better than this scheme. Because the government will still pay the monthly premium of these people in a regular basis" (KII-HB11).

"In addition to this, the currently existing big challenge of the fee waiver scheme, lack of drugs and service in the health centers and hospitals, will be solved in a way that would create a system to refund the expenses of the services or drugs that are bought from the private sectors" (KII-HB11).

"Sometimes, there are people who came to our office complaining about lack of diagnostic services in the public hospitals and unable to afford at private sectors which we couldn't give them immediate solutions. So, we hope the CBHI program will solve this all problems" (KII-HB11).

"The strategy in the future is to incorporate the fee waiver beneficiaries in to the CBHI scheme. And we hope the huge problem within the implementation of the fee waiver scheme will be solved when they are merged together".

"For example, those chronic patients who have been treated for free will not be considered as free patients in the CBHI. And there were also people with pension that were included in the fee waiver scheme that will not be continued later on. They will pay they minimum premium" (KII-HB22).

However, some participants had also reservations on the effectiveness of the CBHI unless the existed poor availability of drugs and services was addressed. One woreda health office head (KII-Ho55) explained her frustration as:

> *"We are now heading to implement community based health insurance. In this case we are convincing the community to pay their premium with the belief they will get quality services. But, with the existing input issue, I don't think it will be successful. The people will ask services for what they pay. Even, the fee waivers are asking their rights to get quality service let alone the premium payers. So, the government needs to work hard to avail necessary inputs".*

- *Existence of organized community volunteers/Aderejajet*

According to this study, there were organized volunteer community members who were responsible for various activities at the community level. These volunteers served as mediators between the community and the government institutions through providing any community related information. Their main responsibilities include but not limited to: facilitate multi-sectorial mission such as maintain security, facilitate environmental hygiene, screening vulnerable for various benefits including fee waiver beneficiaries and tracing unemployed people and facilitate employment opportunities through providing information to the local government institutions.

Hence, the screening process of the fee waiver beneficiaries was facilitated through these volunteers. Woreda health office head (KII-HO55) described these community members as:

> *"They are community people or volunteer of the community such as youth associations, women associations and women development group. These women development group are organized in to one in to thirty and we use them to facilitate the health programs".*

“The groups have leaders from all sectors, like leader for job creation, security, and other issues. If they face any problem, they directly contact the politically assigned officials (woreda) and he/she solves the problem. We let the ketena people (Aderejajet and health extensions) to screen the poor of the poor as they are very familiar among themselves”.

Similarly, one volunteer member(KII-V88) also shared her experiences as:

“*The aderejajets are volunteer community people with different responsibilities like focal for, women development associations, youth associations, security issues, extension, newariwoch focal and other social issues of the community”.*

“*They have division of menders (the smallest administration unit) identity of the areas and work together in an integrated manner. We receive the criteria from the woreda health office and we transfer these criteria and give them guides on how to select, then they conduct the screening”.*

- ✓ *Health facilities governing boards*

According to the manual and regulation for health care financing, establishing governing board for all health care facilities was one of the components health care financing. These governing boards are led by the administrators or equivalent of the respective administration levels and heads of key sectors are members of the board. The main purpose of these governing boards is to manage, evaluate and support the performances of health facilities to provide comprehensive and quality services to their respective catchment populations. One facility manager (KII-FM33) described this as:

"By the way the health center is led by a board and the board is composed of different politicians (woreda administrator, women and children representative, youth representative, woreda finance, community representative, Health center medical director). The board is led by the woreda administrator. Therefore, one of the responsibilities of the board is strict follow up of the fee waiver scheme implementation".

However, this study revealed that the boards were not as effective as they were expected to be. Though they were expected to solve the facilities persistent challenges, it was not happening accordingly. Quotations explaining the poor performance of the governing boards are listed as follows:

"The woreda administrators' lack of responsibilities to take the health issue as the woreda's critical social and economic issue is the problem seen in most of them. So, what is the role of the board, if health is not becoming critical agenda for the woreda?

"Besides, the guideline clearly states that the sub-city to conduct agreement with hospitals and the woredasto sign the agreement with health centers. But these agreements are not going well and no one is taking the responsibility" (KII-HB11).

Similarly, another woreda health office head (KII-HO11) also explained her dissatisfaction on the governing bodies describing her woreda was facing with persistent challenges that should have been solved by the leaders. She described it as:

"Managing the cases of the psychiatric patients and the street dwellers is becoming beyond our capacity. These patients come from all over the region or even the country. But, the board could not give us any solution; they should have made it a discussion point at higher level to give solutions".

4.1.3.2.1.3 Ecological challenges

Ecological challenges are situations in the program area that can be hindrances or obstacles for the implementations of the fee waiver scheme. Some of the challenges mentioned by participants are describe as follows.

- ✓ *Delayed CBHI implementation*

According to some participants, the CBHI piloting process was taking long time and has contributed for the poor performances in the FWS implementation. The preparation of basic prerequisites and equipping health facilities for the implementation was still unfulfilled. One FWS coordinator (KII-HB22) explained this as:

> *"This delayed CBHI implementation is affecting the fee waiver implementation in two ways. First, the attention given to address the problems of fee waiver implementation such as availing supplies and inputs are over looked as the CBHI implementation is now a hot issue for the government officials".*

> *"Second, the process of providing CBHI beneficiaries certificate is creating confusions in health facility staffs especially in differentiating the fee waiver beneficiaries from the premium payers in the CBHI program".*

- ✓ *Complex nature of the city*

The complex nature of the city was also mentioned as a challenge to proper implementation of FWS. Participants suggested to have unique implementation frame work for the city in order to manage the issues effectively.

"As Addis Ababa is the capital city for the country and the seat for African Union and many international organizations, its nature is complex which needs complex management approaches. Hundreds of migrant are entering in to the city from all areas of the region for various economic and social reasons" (KII-HB11).

"These and other factors make the management of the fee waiver scheme difficult. Too much street dwellers and very huge number of people without kebele ID card are some of the prominent problems that affect health service delivery as the demand is beyond its capacity" (KII-HB11).

4.1.3.2.2 Theme two: Population coverage

This theme assessed the extent whether the deserving populations were getting the fee waiver scheme as it is stated in the implementation manual. This theme contained three categories and eleven sub categories as depicted below.

Table 4.4 Theme Two, Categories and subcategories development structures

Theme	Categories	Sub categories
Population coverage	Advocacy and Promotion	Means of promotion
		Promotion as a threat
	Beneficiaries screening process	Functionality of screening committees
		Provision of temporary solutions
		Fairness of the screening and renewal process
		Beneficiaries renewal process
		Beneficiaries screening criteria
	Stakeholders engagement and management	Community Cooperativeness and engagement
		Community resistance
		Implementing sectors coordination
		Implementing sectors capacity and performance

According to the implementation manual, the core principle of fee waiver scheme is to provide poor people with adequate health care services with the principle that states Poor people should not be denied health care services due to their financial problems. Hence, financially poor people were screened through community participation and services were delivered for free.

This finding revealed that the fee waiver implementation has benefitted and saved lives of thousands of peoples in the city, though it has also many limitations. One facility manager (KII-FM33) in KII explained this as:

> *"I can say this is one of the successful programs implemented by government. This is practically implemented on the ground. This is ensuring the utilization of health care for the poor segments. So, it is being realized".*

Most participants of the study agreed that there was no problem of coverage in peoples who have kebele ID card. Participants' quotations with regard to this are put as follows:

> *"If they have ID card, no one is suffering. The problem is for those who don't have the ID card" (FGD2-P3).*

> *"Though it was supposed to cover up to 10% of the population from each woredas, sometimes we find up to 35% and even beyond that during supportive supervision" (KII-HB11).*

> *"All poor people are getting the fee waiver service. Even rich people are also getting this service" (KII-FWB11).*

On the other hand, some of the study participants mentioned that the coverage for people with kebele ID card was still low that there were many peoplethat were not getting the opportunity of free health services. Participants' direct verbatim are put in italics as follows:

"When we go to outreach services for primary health care, we find sick people slept on their bed due to lack of money. They tell us that they don't have money for treatment. As a result, they prefer to stay at home" (KII-FM11).

"When we ask them why they didn't come earlier, they said they were saving money for the health care payment as they are not covered in the scheme" (KII-FM22).

In general, though the progresses made so far were highly appreciated, the population coverage in the city (serving the deserving population) was still very low. The poor populations who had no kebele ID card, vulnerable populations such as street dwellers, disabled people and psychiatric people were not yet addressed and needed special attention from the implementing stakeholders and coordinating bodies at all levels.

4.1.3.2.2.1 Advocacy and promotion

The main purpose of advocating and promoting the fee waiver scheme is to enable all poor families and individuals to be aware of the available health care services free of any payment. Proper and intensive promotion through the right media improves the inclusion of the real and deserving population in the scheme.

According to the participants' opinion, the promotion platforms include: house to house visit, community day events, brochures daily teaching at health centers and using the government structures and community volunteers at all levels.

Utilizing health extension workers as a key vehicle for the information transmission was also one of the most effective means to address the hard to reach households and communities. Participants' quotation with regard to the role of HEWS in promoting the scheme are put in italics as follows:

"I personally hear the program from health extension workers when they tour house to house for health education"(FGD1-P2)*.*

"It is through the health extension workers that we get the poor people who are sick at their home without any knowledge about the program" (KII- HO2).

Organizing community forums and information dissemination at health facilities were also mentioned as promotions platforms. Participants'' verbatim are on this issue are put below in italics.

"The woredas have their own community forums at different times and levels through representatives and even face to face with the community" (KII-HB11).

"We have also customers' day every 15 days. During these days we discuss on the problems like in availability of drugs and reagents in the city. At this time, most fee waivers beneficiaries complain as if it is done intentionally for the fee waivers beneficiaries only" (KII-HO33).

However, despite the existence of such promotion platforms, it was revealed that there were still many people who had no information about the scheme and remained at home especially those elders with no care givers. Participants' responses about this issue include:

"There are also people who don't know the existence of this service; our team is getting people that are sick at their home with simple diseases…that can easily be treated…".(FGD2-P4).

"Ehmm…one day I was suddenly fell down on my way to home due to Anemia… and people brought me to (…) hospital for treatment. At that time, I met my kebele people who know me well and told me to claim to the woreda for the waiver

certificate. Before that, I had no information about free health care services" (KII-FWB22).

Moreover, this study also revealed there were attitudes that consider promotion as a threat. Some of the participants believed the number of people who come and apply for the waiver beneficiaries will be unmanageable when intensive promotion is done. Hence, woredas did not encourage intensive promotion of the service. Program coordinator (KII-HB22) during the in-depth interview explained this as:

"It is difficult to make rigorous promotion. Because, it will be difficult to screen and serve all the applicants as the number will be increased significantly. Even now, it is becoming a challenge to screen the beneficiaries. So, there is huge fear not to promote the service. In some woredas, registered lists are posted in public areas to be criticized by the community which in turn discourages the registration".

4.1.3.2.2.2 Beneficiaries screening process

The beneficiaries screening process starts at community level and possess through various screening process by the established committees and officials before getting final approvals. This study tried to assess the fairness of the screening process, the functionality of the committee and the feasibility of the screening criteria.

- ✓ *Fairness issues and functionality of the screening process*

The fairness issue mainly focused on the involvement of undeserved people in to the beneficiary list or intentional denial of the fee waiver scheme to deserving people for some reasons. According to the finding, there were mixed responses reflecting its positive and negatives sides from their own perspectives.

Accordingly, the screening process was entirely conducted in a fair way that the screening committee members did not pass any unjustified beneficiaries' list to the next level. Besides, the existence of committees at different levels, and the process of posting the beneficiaries list at public areas for critics were stated as main fairness ensuring mechanisms. Participants' quotations supporting the fair side of the process are put as follows.

> *"Even, if I include someone who doesn't deserve, or if I make any mistake, I will be responsible to justify in different stages. The aderejajets (community committee members) will not leave me easily. So it is difficult to make mistakes or including somebody who doesn't deserve" (*KII-V88).

> *"To be fair the most important thing is to be open with the community. That is why we post the list in two or three places in each ketena. The aderejajets (volunteer community workers), who take the responsibility of screening at the lower level is also scared of being criticized for their weakness to properly screen the beneficiaries"* (KII-HO55*).*

However, most participants did not agree with the above pro fairness quotations. they mentioned the existence of un fairness as a major challenges during the fee waiver implementation. Their verbatim regarding lack of fairness is put in italics as:

> *"There are biases during the process that issuing beneficiary certificate depend on the personal interest or willingness of the approval committee"* (FGD2-P2).

> *"For your surprise, there are beneficiaries who are Diasporas and there are beneficiaries who come with their own vehicles"* (KII-FM22).

Diasporas are people who live outside of the country but come to their country for various reasons. It is believed that these people are expected to be modern and rich in relative to the poor society in the country. One waiver beneficiary (KII-FWB11) also supported this issue during the in-depth interview and described it as:

> ***"****There are rich people equally taking service with us. These are rich who have their own house, land and their children are also rich. But, people like us are facing difficulties to pay monthly house rent and unable to eat the food ordered by doctors".*

The inclusion of the relatively rich people in the beneficiaries list was directly affecting the availability of drugs and supplies in health facilities especially in facilities that had no separate pharmacies for fee waiver beneficiaries. Besides, it also raised equity concern in the remaining peoples that were denied from the service due to the screening criteria.

Moreover, significant participants also questioned the process of certificate renewal. The waiver beneficiary certificate serves only for one year when once given and it was expected to be renewed on annual basis. As there might be progresses in economic status and even relocation from places to places, rigorous assessment and investigation was required as was done during the first screening process.

However, the study revealed that the screening process was not strict to evaluate their livelihood. Participants' quotations on this regard as placed as follows.

> *"The screening committee is not working here strictly. Once they gave us the certificate, they don't recheck it again"* (KII-FWB22).
>
> *"We don't regularly recheck it based on the screening criteria"* (KII-HO44).
>
> *"It is only if we get complaints from community that we recheck their economic status by discussing with the community committee"* (KII-HO33).

The major contributing factors for such unfair screening process was mentioned as the poor functionality of the screening committee at all levels. FWS coordinator (KII-HB22) explained this as:

> *"These people (committee) were supposed to identify these problems and raise the issue to the board in every meeting. The cause of poor performances is the non-functionality of the committees at the woreda and sub cities".*

- ✓ *Beneficiaries screening criteria*

The screening criteria set in the health care financing guideline were not exhaustively listed and were not explicit. The guideline gave the lower and middle level offices as initial framework that will be revised by the woredas and sub-cities depending on their respective contexts. Hence, letting woredas and sub cities to modify the criteria's was potentially introducing subjective decisions during screening process and was bringing inconsistent criteria among all sub cities and woredas.

> *"There is no clear cut from the top management side on which poor to select especially on the monthly income level"* (KII-HB11).

> *"If the woreda administration thinks of these expenses could lead these people to poverty in the long run or if they think they could forgo treatment due to the financial difficulties, they can include them in the service. So, it depends on the perspective of the woredas"* (KII-HB22).

> *"Even in people with their income more than 500 birr, if they are with chronic diseases, we let them use the service as these people can't cover the cost of these drugs throughout their life, though it is set to serve only people with less than 500 birr"* (KII-HO55).

The guideline states the minimum government salary scale as one reference point for setting the screening criteria. However, based on the participants' exprince, the minimum standard set was not feasible and applicable on the real economic inflation and cost of livings. Direct verbatim on this regard are as follows.

> *"It is difficult to say one who gets… 500,700 or even 1000 birr can spend to health service after he fulfilled his basic needs"* (KII-HB11).
>
> *"I don't think even one who earns 3000 birr can afford the health care let alone 350 birr"* (FGD1-P2).

4.1.3.2.2.3 Stakeholders engagement and management

Implementation of fee waiver scheme and ensuring its effectiveness is a multi-s stakeholder task that demands proper engagement and management for the achievement of the scheme's goal. Based on the participants' perspective, the performance and engagement level of the expected stakeholders are described as follows.

- ✓ *Community Cooperativeness and engagement*

The community is one of the key stakeholders that have significant influence for the success or failure of the program. Hence, empowering and engaging in key activities and decisions have paramount importance. The community have been serving as a source of information and also played pivotal role in ensuring fairness during selection process. One community screening committee member (KII-V88) expressed the importance of screening together with the all members in reducing biases as:

"Screening together with all community members has the advantages to be free from any biases during the screening process".

Similarly, fee waiver beneficiary (FGD3-P6) explained the role of neighbors in preventing unwanted selfishness as:

"If I have enough money and registered here, my neighbors will oppose me and convince me to leave for those who are poorer than me".

It was revealed that the community also participates in contributing money for those who were not members of the fee waiver beneficiary and for those who lacked money to purchase drugs from private pharmacies.

"When we see sick people in our neighbors due to lack of money, we (the neighbors) *contribute money and help them get treatments"* (KII- FWB11).

However, the participants have also explained that there were some people who resist the implementation of the FWS implementation procedures, especially opposing the posting of names at public for critics. Quotations related to this include:

"Some of them are not interested when their names are posted in kebeles. They… feel ashamed when their name is posted" (KII-HO55).

"They don't want to be criticized by the community; they only want to come and take their certificate" (KII-HO11).

Based on the participants' opinion, these resistances could be due to lack of confidences on the probability of being selected for the service. It was assumed as fear of rejection

from the list as the public will reveal their economic status. Hence, it was mentioned that the mechanism was effective in preventing unfair selections.

- ✓ *Implementing sectors engagement and performances*

- *Poor capacity of implementers*

Lack of knowledge and skills in implementing the fee waiver scheme was widely observed during this study. Most of the study participants were not equipped with the basic knowledge of the FWS implementation process. Only general sensitization training was given for limited health care providers and woreda health office managers on some time ago. Apart from this, formal training focusing on specific fee waiver scheme implementation and management has never been given to implementers and stakeholders.

Direct verbatim associated with the implementing sectors engagement and performances are listed in italics as follows.

> *"I can say we have not yet addressed this capacity building issues all over the implementation areas"* (KII-HB11).
>
> *"When aderejajets (volunteer community screening committee members) are first selected to be a committee member, we tell them what their responsibility will be and then they learn it through the process. Otherwise, there is no official training"* (KII-HO11).

Another woreda health office head (KII-HO22) shared her experience on how lack of orientation affects the quality of their screening process and said:

“One day we provided orientation training for the community based screening committees and let them re screen those who were prepared as potential beneficiaries. Then, they found about 182 rich people from the list that were later excluded”.

Therefore, effectiveness of the FWS implementation can be enhanced through intensive capacity building for those who are involved in the process and through collaboration and integration among sectors.

- *Weak performance of implementing sectors*

According to the health care financing guideline, labor and social affairs and women and children affairs are the key implementing sectors at all levels. These sectors were expected to identify, register and screen, issue certificates and manage the process of their respective vulnerable societies. The vulnerable societies include street dwellers, homeless individuals, disabled and psychiatric people, elder people and children with no care givers etc.

However, these study findings revealed that these sectors were not actively engaged in the implementation process let alone showing promising performances. Head of woreda health office (KII-HO55) during in depth interview described this as:

“They don’t even have any information to support and solve such issues. May be in the region, they might be informed, but here in the woreda, they don’t know it”. He continued “The office has lots of works with the street dwellers but in terms of screening for fee waiver, they are not yet involved".

Other medical director of health facility (KII-FM2) also described her frustration about the poor management of street dwellers as:

"We can say the fee waiver scheme is not addressing the street dwellers though they are very poor and vulnerable".

When asked why sectors were not actively involved, Program coordinator (KII-HB22) responded as:

"Yeah, street dwellers issue is expected to be facilitated by the labor and social affairs office. We have been trying to work with them to address the health care needs of the people without the formal ID, but it is not yet successful. So, it needs common strategy to ensure this issue nationally. Our main job is to avail health service for citizens in our facilities".

Similarly, head of woreda health office (KII-HO22) described his frustration about poor performance of the social sectors during in depth interview as:

"*I always get people in front of my office who beg for free service. But, these people are without ID card that we couldn't manage it with the existing policy. It is very difficult to convince especially psychiatric patients; as they don't understand us. So, it's very disappointing".*

4.1.3.2.3 Theme three: Services Coverage

This thematic area assessed the capability of health facilities to provide comprehensive, quality and advanced Health care services to the fee waiver beneficiaries free of any payment. According to the health care financing guideline, the fee waiver beneficiaries should be provided with full and comprehensive health care services at public health facilities. This thematic area contained four categories and seven sub-categories as depicted below.

Table 4.5 Theme Three, Categories and subcategories development structures

Themes	Categories	Sub categories
Service coverage	Resources and infrastructures	Shortages of drugs
		Lack of equipment
		Lack of Skilled health care professionals
	Staffs perspective	Provision of service equally
		Flexibility and Context management
	Health service quality	Lack of comprehensiveness and compromised quality
	Stakeholders demand	The need to equip health centers

According to this study results, there were no intentional service limitations or service denial for these beneficiaries. However, poor capacities of facilities and poor managements of the implementations have caused the beneficiaries to face with limited services at the public facilities. Based on the participants' responses, the determinant factors associated with poor health services coverage are described as follows.

4.1.3.2.3.1 Lack of drugs and medical equipment

- ✓ *Shortages of drugs*

Most patients and implementers stated that the most expensive component of the health service delivery was the price of drugs especially for chronic cases and some diagnostic services. However, it was revealed that the most prominent challenging issues in health facilities were lack of drugs, x-ray machine and ultrasound machines. And hence, they question if the government was providing services for free.

Almost all beneficiaries, implementers and managers agreed on the issue of drugs unavailability. Lack of drugs in the health facilities was one of the major barriers for the

poor to access health care services. Beneficiaries were told to buy drugs from private pharmacies. As beneficiaries can't afford to buy drugs from these private pharmacies, they preferred to forgo the treatment and go back home to sleep at the expense of their life. Participants'' quotations about these issues are put in italics as follows.

> *"We are told to buy from outside in private pharmacies. How can we buy it out side? If you can come to our home, you can see how we are living, how we are managing our family. Especially, the expensive tests and drugs are not found here. For example, there is one test for urine which is expensive and not found here"(*KII-FWB11).

> *"Since we don't want to die we may buy it at the expenses of other life expenses. Its name is for free, but I don't see its importance if we can't get drugs which covers most of the cost. So, where is the free treatment service? If I am paying this much amount for drugs, I prefer not to be named free service beneficiaries for nothing"* (KII-FWB22).

Similarly, head of woreda health office (KII-HO44) questions the importance of fee waiver scheme as:

> *"We said, these people are poor, so how do we say we are serving them properly without providing drugs to them? The biggest costly thing is I think drugs. And we are not availing them, it is contradicting".*

Especially, the price of drugs for chronic diseases was very expensive that beneficiaries can't afford to buy consecutively for longer times. Head of woreda health office (KII-HO11) expressed the seriousness of the problem as:

“We started providing psychiatric service in every Thursday. But, the problem is the drugs for these patients are very expensive and no one can afford them. So, we are in trouble now. We are telling them (the psychiatric patients) their health problems but we are not providing them the drugs for these poor people”.

Another, fee waiver beneficiary *(*KII-FWB11) described her experience and feeling during in-depth interview as:

“First, I go to the pharmacies and I ask its cost. If it is small, I buy it by reducing from my food. But, if it is greater than 100 birr, I leave it and sit at my home. Mostly, I don’t buy drugs as they are very expensive. That is why I am coming to hospitals repeatedly. It is because I didn’t take the drugs that were ordered last time”.

Despite the fact that shortage of drugs was one of the major challenges that the fee waiver beneficiaries were suffering from, this study has also revealed the existence of optional initiative to solve this problem. Some health facilities have started availing drugs for only fee waiver beneficiaries through separate pharmacies. FWS Program coordinator (KII-HB11) described this initiative as:

"There are health facilities that have drug store that serve only for fee waiver beneficiaries. For example, Zewditu hospital doesn’t sell drugs to paying patients during the day time. They have kenema pharmacy in the compound that sells to the paying patients. There are also few health centers that reserve the drugs for these waiver beneficiary patients”.

- ✓ *Lack of medical equipment and diagnostic service*

In addition to shortages of drugs, lack of medical equipment such as x-ray, ultrasound and laboratory machines and lack of diagnostic services at health facilities were also the major barriers to access health care by the poor society.

Mostly, health centers refer patients to hospitals if these services were needed. When patients were referred, they were told that these machines were not functional. As a result, the poor were forced to forgo the treatment or to get in to debt to purchase the services. Participants' verbatim with regard to the above issues are listed in italics as follows.

> *"Drugs are not available most of the time and even, urine test is not available. Especially, if they ordered us blood test, it is obvious we must buy from private. Other services such as X ray, ultrasounds etc. are totally not in the health center"* (FGD2-P2).

> *"Mostly machines/equipment are not functional at hospitals. So, the patients prefer not to go to hospitals"* (FGD2-P5).

> *"When we come to the diagnosis, the hospitals themselves sent you to private facilities for different tests. It is really disappointing. I don't personally want to go to hospitals. I would rather die here"*(FGD1-P2).

> *"They (beneficiaries) believe the hospitals are not by far better than health a centers. That is why peoples in Addis Ababa don't want to visit hospitals. The hospitals are more complicated than the health centers"* (KII-HB11).

4.1.3.2.3.2 Human resources for health care services

Skilled and experienced health care staffs are among the critical inputs required to provide comprehensive health care services. Opinions related to health care staffs and their impact on services coverage are analyzed and described as follows.

- ✓ *Lack of skilled professionals*

According to the participants' view, lack of skilled and senior professionals such as medical doctors and radiologists in health centers were among the reasons not to get comprehensive health care services. Medical doctors, radiologists and other higher professionals were mostly assigned in big hospitals. The scheme's Program coordinator (KII-HB11) described this as:

> ***"****Lack of higher professionals is a big problem. It (equipping health centers with materials and machines) needs professionals such radiologists to investigate. That is the challenge. We are still lacking these professionals at hospital let alone health centers".*

According to the participants, both the skilled professionals and the provision of advanced material need to be considered together. Otherwise, purchasing the machines and installing in the facilities will not have any impact in the service provision. Head of woreda Health office (KII-HO33) shared this concern as:

> *"Even if we start the advanced services, we lack skilled professionals. That is why we send them (the beneficiaries) to hospitals".*

- *Implementing Staffs' perspective towards Fee waiver scheme and beneficiaries*

According the finding, the health care providers and facility managers witnessed that the fee waiver implementation was a good opportunity for the improvement of the health facilities in terms of improving financial capacity and service quality. Head of woreda health office (KII-HO55) stated this as:

> *"The facility gets more payment as they give more services. So, when we ask them if this happens, they say they are losing their income if they return their patients. So, they say they don't return them and they try to avail every drug and services as much as possible".*

Similarly, another medical director (KII-FM22) also explained her opinion on the importance of the scheme even for her satisfaction as:

> *"…. I get relief when they tell me they are waiver beneficiaries. Most of the beneficiaries are chronic cases and elders, so I get excited with this".*

> *"When the staffs know the patient is waiver beneficiary; they get relief from worrying and paying from their pockets for the beneficiaries"* (KII-HB22).

With regard to attitude to fairness of service provision to the beneficiaries, mixed opinions were found from the implementers and waiver beneficiaries. The waiver beneficiaries believed they were discriminated due to the fact that they are not directly bringing cash to the facilities. They believe priority was given for the paying patients in various service provision aspects. One fee waiver beneficiary (KII-FWB11) stated this as:

> *"They (pharmacists) say there are no drugs, though the drugs are there waiting for the paying patients".*

However, the perspective from the implementers and managers was different that there was no any situation in which the beneficiaries can be discriminated. Participants' opinions on this regard are put in italics as follows.

> *"If you are a father with many children, you are responsible to treat or manage them equally. Similarly, the woreda is responsible to treat its woreda dwellers equally like the children. For free doesn't mean free at all. The woreda will pay for it. So why do we make differences? There is no difference at all"* (KII-HO33).

"It is only the medical record staffs that are aware of their status when registering the information and expenses" (KII-FM22).

"In the previous times, it has been written in their card that they are fee waivers beneficiaries. But now, it is removed from their card and no one except the card room staffs knows their status. If they are told that there is no drug or reagents, they consider it as if it is done because they are fee waiver beneficiaries, which is not the reality" (KII-FM22).

- ✓ *Health facilities Staffs commitment and cooperativeness*

Serving in health care facilities in areas where poor people were not guaranteed for the service due to various reasons was a very challenging task. When diagnostic services such as x-ray and ultrasound services or drugs were not available in the facility, the fate of these poor people was either going back home to sleep without any care or compromise their daily basic needs including foods and buy the services. During such instances, health care providers managed these issues in different ways. Medical director (KII-FM3) of one facility stated this as:

“Most patients are chronic cases. And drugs for these chronic cases are rarely available in the city. But, for the sake of them we tried to call all over the pharmacies and health facilities in the city and we bring from facilities that have less caseloads as loans”.

Similarly, these staffs also manage difficult situations in the health centers through money contribution and give to patients to buy drugs or other diagnostic service from private organizations. The regional program coordinator (KII-HB22) stated this as:

“Staffs contribute money from their pocket and let the patients do their test outside in private clinics. If the money contributed doesn’t fit the expected payment, they even call to the private clinics and negotiate with them to provide the test in a discounted price”.

There were also times when the social workers of hospitals write cooperation letter to private clinics with a request for cooperation to provide free service or at least with discounted fee for the listed name of patients. Social worker of one facility (KII-SW22) supported this idea as:

“If their tests are not available in the facility and if we believe that it is critical, we write letters to the private clinics requesting to cooperate the beneficiaries for free or at least with discounted price”.

4.1.3.2.3.3 Issues of Health services quality

Provision of quality health service is one of the key components for improved service coverage. Providing quality service has various dimensions that need special attentions

from managers and implementers. The study findings are categorized under the following sub categories based on the opinions of the participants.

- ✓ *Lack of comprehensive and quality services*

Lack of comprehensive services in the health facilities was one of the major problems that beneficiaries were facing during the fee waiver implementation, according to most participants. Though the fee waiver scheme was intended to improve the financial capacity of facilities due to the reimbursed money from the government body, it was not happening as expected. Lack of drugs, reagents, machines and skilled professionals were the major reasons causing for the lack of comprehensive service delivery. The regional program coordinator (KII-HB11) stated this as:

> *"There are people who came to our office complaining about lack of diagnostic services in the public hospitals and unable to afford at private sectors which we couldn't give them immediate solutions".*

The main root cause for these problems was the facility management's poor commitment and lack of budget as woredas were not reimbursing on timely basis.

> *"Though I can't remember the exact amount of money, almost all sub cities have debt that needs to be paid to hospitals. So, the facilities can't provide quality services due to such financial and input problems" (KII-HB22)*.

Most of the study participants suggested that health centers should be fully equipped with necessary equipment to address the needs of most population. Direct verbatim of the study Participants are stated in italics as follows.

“Make the health centers comprehensive, all service needs to be given here (Health center)"(FGD1-P4).

"Introduce x ray, ultrasound in the health centers. Most people don’t pay for X ray and ultrasound because they are expensive. So, it is better to mobilize resource or search for sponsors and bring them here" (FGD1-P6).

"The physicians should come to the health centers rather than being limited at hospitals. This is the most crowded service area, so they need to come here and serve the population" (FGD1-P1).

"Hospitals are very crowded. So, it is better to make health centers equipped with materials and staffs and make them convenient and effective"(KII-HO33).

4.1.3.2.4 Theme four: Financial protection

The fourth thematic area, financial protection, examined the extent of the beneficiaries facing financial difficulty due to paying for medical services. This thematic area comprises three categories and four sub categories as shown below.

Table 4.6 Theme four, Categories and subcategories development structures

Theme	Categories	Sub-categories
Financial protection	The scheme meets its purpose	Prevented death
		Prevented impoverishment
	Compromise basic needs	Pay for drugs at the expense of food and living consumables
	Sacrifice own health to take care of family	Prioritizes feeding family members instead of paying for health care

The health care financing implementation manual states the screened beneficiaries were expected to get health services for free. Some participants witnessed its effectiveness in protecting the financial conditions of individuals. According to these participants' response, the fee waiver scheme was preventing many people from death and financial impoverishment. Heads of two woreda health offices stated this as:

> *"It (the scheme) is really very important, because, it is serving the poor and sick people. Which I believe is very exciting. Especially, these days, health services are getting very expensive that can't be afforded. So, for those who see their health issue with respect to the money they have, it is very promising as It is preventing people from dying at their home due to lack of money"*(KII-HO22).

> *"It is really successful; it has saved so many people from death and impoverishment" (KII-HO11).*

However, majority of the study participants agreed that the poor were facing financial difficulties as they were forced to buy the service from private organizations or enabled to forgo treatment due to impoverishment. Opinions of participants with this regard are categorized and stated in italics as follows.

4.1.3.2.4.1 Compromised basic needs

The fee waiver scheme guideline states that poor people can get comprehensive health care service regardless of their ability to pay. However, when we come to implementation, the participants stated that the reality was different. According to them, fee waiver beneficiaries were still forced to pay for health care services to save their life. Lack of adequate drugs and diagnostic services at health facilities were making the poor people to head in to financial trouble and compromised basic needs. Beneficiaries witnessed during their FGD and in depth interviews that they were still paying for private

health care companies' due to lack supplies and facilities at the public health facilities. Participants' verbatim are stated in italics as follows.

> *"Though we are poor, we buy it to save our life. The services outside* (private organizations) *are very expensive. But, since we don't want to die, we may buy it at the expenses of other life expenses"* (KII-FWB22).

> *"People like us are facing difficulties to pay monthly house rent and unable to eat the food ordered by doctors. For example, when they (doctors) order me drugs, first I go to the pharmacies and I ask its cost. If it is small, I buy it by reducing from my food. But, if it is greater than 100 birr, I leave it and sit at my home"* (KII-FWB11).

> *"May be we can get the beds for free. Otherwise, we are forced to buy the drugs outside. But to save our lives we buy it from outside even with loans from friends"*(KII-FWB11).

Similarly, regional program coordinator (KII-HB22) also stated the frustration of health care providers to contribute for patients due to lack of drugs as follows.

> *"Now, they (staffs) are complaining about paying for patients, as it is happening frequently and is becoming beyond their ability to manage".*

4.1.3.2.4.2 Sacrifice of own health to take care of family

According to the finding, denying health care service for the sake of children's food and basic needs were common among fee waiver beneficiaries. Parents were scarifying their lives for the survival of their children. Direct quotations of the participants on this regard are stated in italics as follows.

"We can't buy the drug at the expenses of our children stomach. I personally leave buying the drug to feed my children. I always prefer to get sick, instead of making my children hungry" (FGD3-P2).

"We have lots of issues to manage; we have students to take care and other living expenses. I know when i don't get these drugs, my blood pressure raises, but I don't have any option" (FGD1-P4).

"We don't visit health care facilities for medical checkup as it is very expensive. That is why we are becoming sick as we don't make medical checkup regularly due to lack of money. When we come to utilize this fee waiver program, the treatment is not there"(*FGD1-P4*).

Similarly, another waiver beneficiary (KII-FWB22) during an in-depth interview strengthened the denial of services due to lack of money as:

"Mostly, I don't buy drugs as they are very expensive. That is why I am coming to hospitals repeatedly. This is because I don't take the drugs that were ordered last time. Look my color, last time the doctor ordered drugs for my face and hands. But, I couldn't afford it. Look my face is getting black from time to time because i can't manage the price due to financial burden".

4.1.3.2.5 Theme Five: Performance Management

This theme assessed the monitoring, evaluation and accountability component of the fee waiver scheme. Opinions of the study participants were categorized and sub categorized as follows. This theme was developed from three categories and five sub categories as shown below.

Table 4.7 Theme Five, Categories and subcategories development structures

Theme	Categories	Sub-categories
Performance management	Monitoring and Evaluation Framework	Lack of accountability tools
	Information management and documentation	Beneficiaries profile
		Service utilization reports
	Performance monitoring and evaluation	Lacks performance measurement tools
		Lacks regular monitoring practices

4.1.3.2.5.1 Monitoring and Evaluation Framework

Monitoring and Evaluation framework is a performance and accountability governing framework that indicates the implementation progress and effectiveness of programs. Frameworks embrace performance indicators, expected deliverables and the accountability of the implementing stakeholders. It serves as a key tool for performance management and resource for evidence based decision making.

According to the researcher's document review finding, there was no any monitoring and evaluation frame work intended to show the implementation status of the fee waiver scheme. As a result, performances of the stakeholders were not objectively monitored and evaluated. It was difficult to measure their progress without setting performance indicators, targets and expected deliverables.

Based on the document review and observation made by the researcher, absence of monitoring and evaluation frame works has contributed for the poor performances of various components of the fee waiver scheme. The outcome brought by the scheme and the performance trends of its components couldn't be measured and tracked.

4.1.3.2.5.2 Information management and documentation

According to the health care financing guideline, any relevant information including list of beneficiaries, services utilization and costs incured should be handled properly and compiled on quarterly basis for decision makings. Based on the study finding, the documentation and data management process was properly managed and documented. Direct verbatim related this are stated in italics as follows.

> *"We have separate register at the card room, and it is well documented on monthly and quarterly basis in separate formats. Then we compile it quarterly and send to the woreda both paper based and electronic based. We put also copy of it with us"* (KII-FM33).

> ***"****It* (the registration) *is done based on the service consumed. Our card room staffs register every service consumed and converted to money. Then we request the money for reimbursement. Besides, we also report the number of the beneficiaries and their respective amount money consumed to the sub city ethical office and to the health care financing office on monthly basis"* (KII-HO22).

4.1.3.2.5.1 Performance monitoring and evaluation

Performance monitoring and evaluation mainly focused on tracking and measuring the routine performances. It checked if performances were according to the plan and assessed if the program implementation was on the right track to achieve the desired objectives.

Hence, it was found that there was no any guide on how the monitoring and evaluation process should look like and there were no clear indicators that can measure the

program implementation status. The governing board of Health facilities were expected to evaluate facilities performances every six months. Head of one woreda health office *(KII-HO11)* stated this as:

> *"We present our performance for the board biannually; the health center is led by a board that regularly evaluate us how we fairly perform this fee waiver system. As a teshuami (politician or cabinet member), If there are unfair things in the woreda, everyone is expected to justify for it. We will take the risk. We present our performance against plan".*

However, this study revealed that there were lots of critical challenges that the board and facility managements were not able to solve. Lack of consistent drugs and supplies, poor financial reimbursement, biased screening process and existence of subjective screening criteria were among the major concerns that need to be addressed by the board. Quotations of the study participants are stated in italics as follows.

> *"There are limitations in the monitoring and evaluation by the higher officials. It should not be for the sake of saying we have fee waiver program. There should be strict follow up for the availability of inputs and quality services in the Health system. So, it is difficult to say the board is functioning up to its expectation as the persistent issues of the system' are not yet solved"* (KII-HO44).

> *"There are people who don't deserve to be fee waiver beneficiaries. But, they are there. We usually raise this issue to our medical director and he raised it in different meetings. But still the problem exists. This shows the poor decision making ability of the leadership"* (KII-FM22).

Correspondingly, the regional program coordinator (KII-HB22) also suggested that there are gaps in monitoring the progress from the woreda and sub city side as:

> *"Woreda administrations don't monitor the quality of service provision and the facilities don't influence the woredas for reimbursement rather they request the health bureau for reimbursement. Similarly, sub cities don't cross check the proper implementation of the screening process".*

He continued:

> *"The coordinating body at all levels and the governing board is not properly monitoring the implementation process. For example, the regional health bureau is responsible to give technical support to sub cities, and sub cities are responsible to control and support woredas. However, many woredas are complaining for lack of technical and administrative support from sub cities and regional levels".*

Lack of generating evidences to help for routine performance improvement and to make evidences based decisions were also mentioned by the participants. This was further strengthened by regional program coordinator (KII-HB11) as:

> *"Emm…. even though we don't have tangible evidence to confirm these, there are rumors that say there are rich people who come with their own car and utilize the fee waiver services. So, I can't say it is false. But, it needs to be evidence based with researches and even this study could serve as an input for generating evidences for such cases and hope it will show us size of the problem in the city".*

Besides, lack of adequate budget for review meetings and supervisions were mentioned as reasons for the lack of performances monitoring which also showed poor government attention to monitor the progress.

"This program was supported by Partners so far. However, they are now on the phase out stage. So, to organize separate review meetings and monitoring, there are many problems like lack of attention to the program, lack of budget and lack of adequate and skilled staffs that can conduct supportive supervisions and reviews" (KII-HB22).

4.1.3.2.6 Theme six: Leadership and Governance

This thematic area addressed the findings about the performances of the coordinating bodies at all levels, the government political commitment and the decision making ability in general. The fee waiver scheme implementation seeks multi-sectoral and multi-stakeholders' involvement and collaboration to get the best out of it. Besides, since it is aiming to address the health needs of the economically deprived population, it is sensitive issue that needs special attention from the political leaders.

Table 4.8 Theme Five, Categories and subcategories development structures

Theme	Categories	Sub-categories
Leadership	Coordination and Management	Strategies and guiding documents
		The need for separate management structure
		Lack of appropriate bilateral agreement
		Poor financial re imbursement
	Lack of decision making	Actions are to taken despite poor performance
	Political ownership and commitment	Governments' Budget allocation

4.1.3.2.6.1 Coordination and Management

The fee waiver scheme has coordinating and implementing stakeholders. These stakeholders have their respective hierarchical responsibilities at all levels. The regional

administration for Addis Ababa city, sub-cities and woreda administration offices are the main owners and coordinators of the fee waiver scheme implementation at their respective levels, according to the .

However, according to this result, there were many implementation and coordination limitations that hinder its effectiveness. The coordination and management bodies need to be conscious to understand, analyze and solve these limitations. Opinions of the study participants are categorized and stated in italics as follows.

- ✓ *Compromised guiding documents*

Ensuring the existence of adequate, updated and comprehensive strategies, guidelines and protocols were among the core responsibilities of the coordinating bodies at all levels. According to the document review, Addis Ababa city administration has developed and launched a regulation called health services delivery and health facilities administration and management regulation, 26/2009in November 2009.

Following the launching of the regulation, Addis Ababa regional health bureau prepared and launched the health care financing reform implementation manual in May 2010 where the fee waiver scheme was mentioned in as a chapter. Under this chapter, components of the fee waiver implementation process including initial screening criteria were described shalowly. The manual stated that the detail screening criteria will be further refined and contextualized by sub cities and woredas as needed.

However, according the finding, lack of centrally agreed and standardized criteria in the city has created inconsistencies and misinterpretations by all implementing bodies at all level. As a result, woredas were forced to use inconsistent screening process by themselves, according to the participants. One woreda health office head (KII-HB55) stated this as:

> *"We are compromising the criteria. Because we know the minimum criteria, less than 500 birr, is nothing. Even I don't think there is 500-birr monthly salary these*

days. Even 1500-birr monthly salary can't do anything. By the way the benefit of the aderejajets (volunteers serving as community screening committee) is to contextualize the problems with existing value of money" (KII-HO55).

Similarly, regional program coordinator (KII-HB22) also strengthened the subjective judgments of woredas as:

"If the woreda administration thinks of these expenses could lead these people to poverty in the long run or if they think they could forgo treatment due to the financial difficulties, they can include chronic patients in the service. So, it depends on the perspective of the woredas".

The Inclusion of people affected by chronic diseases in to the beneficiary list was also another issue that the woredas were treating it inconsistently. According to the participants' opinion, people affected with chronic disease such as diabetes, hypertension etc were included in some woredas whereas in other woredas, such chronic cases were excluded from the beneficiary list as they only consider the salary scale of these people. The regional program coordinator (KII-HB11) quoted this as:

"The guideline is not comprehensive that it put only the monthly income and doesn't address the issue of patients with chronic diseases".

Similarly, another regional program coordinator (KII-HB22) also pointed the need to have standardized criteria for the city as a whole.

"There is no need to let woredas set their own criteria as the livelihood standard of the people in the city is almost similar. The screening criteria should be revised in

a way that can serve for all woredas in the city. This standard should be standardized, objective and valid that considered the living standards of the society".

Moreover, participants revealed that the management of street dwellers and people with no kebele ID card issue also lacked clarity which in turn caused confusions among the implementers. Labor and social affairs officer of one woreda (KII-LS99) during in depth interview expressed this as:

"There is no clear direction and guidelines on how to serve or manage people with no kebele ID card".

- Stakeholders *lack clarity on the implementation procedures and responsibilities*

Though various comments and suggestion related to the standardization of the guideline and screening criteria were forwarded to the regional health bureau, the bureau was not responding to these suggestions. The reason was due to the fact that the bureau thinks it was not its mandate to make this amendment. Regional program coordinator (KII-HB22) quoted this as:

"We always think that the guideline must be revised; but, it is not our mandate. May be our mandate is identifying the challenges in implementation process and send to the responsible body for amendment. This is the problem of the health bureau".

The guideline allows the labor and social affairs office and women and children affairs at all levels to identify and register the street dwellers, elders and children and screening for the beneficiaries' services. However, there were inconsistencies of knowledge levels across all coordinators and implementers about the implementation guideline, screening criteria and its applicability. Labor and social affairs officer (KII-LS99) during in depth interview expressed this as:

“There is no clear direction and guidelines on how to serve or manage people with no kebele ID card”.

Besides, though the regional health bureau was expected to provide technical supports to the sub-cities and woredas, it was not happening as expected. Regional program coordinator (KII-HB22) stated the lack of technical support issues as follows.

“Many woredas complain that the regional health bureau doesn’t provide them necessary technical supports. It was for the first time since 1995to meet with the woreda people and gave them training on health care financing just few weeks ago".

- ✓ *Lack of independent and separate management structure*

According to the participants’ opinion, most of the implementation support and follow up were being done by the health sectors at all levels. However, the participants suggested that the health sectors need to be focusing only on the provision of the quality health services to the beneficiaries instead of coordinating the processes. Quotations of the participants on this regard are put in italics as follows.

"It is better to manage this fee waiver implementation process through independent body like FMHACA (an abbreviation for Food, Medicine, Health Administration and Controlling Authority) to follow, monitor and evaluate the service” (KII-FM33).

“The main cause for poor performances is due to the fact that there is no independent body to cross checks the implementation statuses. Since both the health facility and the woreda administration are government organizations, there is no such a big influence on each other to confront their respective weaknesses” (KII-HB22).

In addition to the demand for the independent structure to manage the implementation process, health office managers also found it very difficult to manage such huge activities through existing staffs as an additional task. They suggested that there must be one full time focal person at least for health care financing issues at woreda and subcity health offices that can manage the process. Head of woreda health office (KII-HO44) described this during the in depth interview as:

> *"It could be better if separate focal person could be assigned to manage the health care financing program separately. It is now led by committee which is suspended between the administrator and the woreda health office".*

- ✓ *Lack of appropriate bilateral agreement and poor financial reimbursement*

According to the guideline, it is suggested that there need to be bilateral agreement between health centers and woredas and hospitals and sub-cities. The bilateral agreement needs to be done also among regions and federal hospitals. However, according to the participants' responses, it was not practically implemented accordingly. Direct verbatim of the participants are put in italics as follows.

> *"Hospitals don't have any agreement with regions. They provide the service to the regional beneficiaries, document the service and its price, and complain to the health bureau. But we are still confused with no solution" (KII-HB22).*

> *"If they (beneficiaries) come from regions with their fee waiver beneficiary's certificate and referral paper, we provide them the service and register the expenses they utilized. But, there is no any agreements with the regions that enable them reimburse our expenses. We simply serve them and our hospital covers the costs" (KII-FMR11).*

With regard to the financial reimbursement, health facilities were expected to request their reimbursement to the woredas and sub cities on quarterly basis. Following the request, the finance and economic offices need to make payments to the health facilities within five working days. However, health facilities were facing challenges from lack of money due to poor financial reimbursement from the responsible bodies.

As a result, the participants witnessed that provision of quality health service to the beneficiaries and to the public in general was highly compromised. As they could not equip their facilities with necessary inputs such as drugs, reagents and machines. Direct verbatim of the participants are put in italics as follows.

> *"Facilities are suffering from lack of reimbursements. There are facilities that have not yet get paid around 57-86% of their money. There is one sub city with 1.7-million-birr debt. Though I can't remember the exact amount of money, almost all sub cities have debt that need to be paid to hospitals. So, the facilities can't provide quality services due to such problems" (KII-HB11).*

> *"Since there is no proper refunding mechanism, the capacity of the health facilities is very weak. As a result, comprehensiveness and quality of service is also compromised"(KII-HB22).*

When assessing the major causes for the poor financial reimbursement, participants stated their suggestions in italics as follows.

> *"The cause of the problem (poor bilateral agreement) is the non-functionality of the committees at the woreda and sub cities. When the woreda identified their beneficiaries, they should have sent the list to the sub city and the sub cities should have compiled all woredas beneficiaries and give the list to the hospitals*

when making agreements. But, this is not happening accordingly, that is why hospitals are not reimbursed by sub cities on timely basis" (KII-HB22).

"The main problem with the fee for service is the woreda doesn't consider the price of services and the frequency of visits while budgeting for them. Besides, even if they allocate budget, they shift the money to other issues when need arises" (KII-HB11).

The other reason that caused poor financial reimbursement was lack of money at the woreda or sub city during the requested period. Sometimes, the finance and economic offices utilize the fee waiver budget for other payments. Hence, it takes long time to replace the money and reimburse for the facilities.

"They shift the money to other issues when need arises. As a result, they face challenges when asked to reimburse for the health facilities" (KII-HB11).

"When the woreda lacks money they just request the Health center to give half of the money and to pay the rest later on" (KII-HO44).

Moreover, it was also found that lack of timely and appropriately request by health facilities was one factor for the delayed reimbursement process. The health facilities management lacked commitment to actively request and follow the process as expected.

"Some health facilities don't request their payment due to the fact that both are government institutions. They don't care whether they take it or not" (KII-HB22).

4.1.3.2.6.2 Lack of decision making

Based on the health care financing guideline, health facilities are led by governing boards. Composed of key sectorial leaders, the board is chaired by the head of the woredas, sub cities or equivalent positions. The main purpose of establishing a board with multi-sectorial officials is to make valuable decisions during the implementation as it demand a multifaceted and multi-sectorial problem solving attitudes.

The board is responsible to understand the implementation status of the health care financing, including the fee waiver scheme and make decisions that resolve implementation challenges and bottlenecks. The board meets every six months and evaluates biannual performances of health facilities in all programs.

However, according to the finding, there were various persistent challenges that the board and the management bodies at all levels have not yet solved. Lack of decisions and actions to correct the poor performances of all implementing organizations was one of the challenges. It has been described that the implementing sectors have not been performing up to the standards. Hence, actions that should have been taken were not taken to improve their performances. Direct quotations of the participants in this regard are put in italics as follows.

> *"If facilities and implementing offices do not perform according to the guideline there must be punishment that can correct the mal actions. But no one is doing this" (KII-HB11).*

> *"The cases of the psychiatric patients and the street dwellers is becoming beyond our capacity. These patients come from all over the region or even the country". I don't know why the board or the management of the facilities do not take actions on this (KII-HO11)".*

4.1.3.2.6.3 Political ownership and commitment

The woredas, sub cities, and the regional administration offices are responsible to lead the program through the support of established committees at all levels. However, based on the findings, theses administrators used to give priority for other political agendas and left this issue to health sectors only. Participants' responses are put in italics as follows.

“What we are observing is, the woreda or sub-city administrators give the ownership to the respective health office heads which is wrong and out of the guideline"(KII-HB22).

"We need to be service providers; another independent body need to screen the beneficiaries. Like the woreda administrator, or the labor and social affairs should take the program. We shouldn’t serve as both supplier and purchaser at the same time" (KII-HO11).

"The woreda administrators lack commitment to take the health issue as critical social and economic issue. This problem is seen in most of the administrations at all levels" (KII-HB11).

4.2 PHASE TWO: DEVELOPMENT OF FEE WAIVER SCHEME IMPLEMENTATION FRAMEWORK.

4.2.1 Introduction

Phase two of this study aimed to develop fee waiver scheme implementation frame work based on the thematic areas developed from during phase one. The researcher first drafted a preliminary implementation framework based on the themes emerged during phase I. This implementation framework is composed of six strategic objectives, 27 core interventions and many major activities. Once, the preliminary framework is drafted, a validation checklist and criteria were developed by the researcher. The checklist was developed in two categories: strategies and core interventions which were validated separately. These strategic objectives and core interventions were validated based on five points Likert scales ranging from very high to very low.

The validation criteria employed during the process include: relevance, achievability and impact for the strategic objectives and two additional criteria such as specificity and clarity were also used to validate the core interventions. Then, a delphi technique was employed to collect the participants’ scores based on the set criteria. Study participants were selected purposively based on their rich experiences and in depth knowledge on the fee waiver implementation. Seven participants were selected and communicated for

the study, though two of them were not active in responding the requests. Hence, five study participants were participated in the validation process. These participants were extracted from ministry of health, regional health bureau, implementing Partners and from woreda health offices.

The validation processes were conducted in two steps: validating the strategic objectives and the core interventions. Once the strategic objectives are found valid based on the criteria, and then the experts go further in to validating the core interventions under each SOs. Consequently, the researcher analyzed the findings and proposed them as strategic objectives and core interventions of the implementation framework. According to the experts' agreement, the strategic objectives and core intervention with mean score above 85% were taken as acceptable and valid. The data collection process took place from April 08-19 2019.

4.2.2 Validation Results

4.2.2.1 participants socio demographic characteristics

The researcher purposively selected seven professionals for the validation process and sent them an invitation letter to participate and to validate the preliminary implementation framework. However, two of them were not able to respond to the invitations on the specified time frame due to various personal reasons that only five professionals have participated on the validation process. The participants' total service years' ranges from 8 to 22 years with an average of 15 years on the health sector. Their academic qualification ranges from BSC to PhD. Particularly, there were one PhD, two PhD candidates, one MSc and one BSc holders. These participants were drawn from ministry of health, regional health bureau, woreda health office and from partners. Unfortunately, all of the participants were men that gender composition was compromised.

4.2.2.2 Validation process

Table 4.9 Theme Five, Categories and subcategories development structures

Criteria	Five points Likert scale				
	Very high(5)	**High(4)**	**Medium (3)**	**Low (2)**	**Very low (1)**
Clarity					
Specificity					
Relevance					
Applicability					
Impact					

As depicted on the above table, the researcher employed five validating criteria along with five points likert scale to assess the validity of the preliminary strategic objectives and core interventions within the implementation framework. The criteria were operationalized as follows in a way that could be easily understood by the validators.

Clarity: Assesses whether the strategic objectives and core interventions are clear and easily understandable by the implementers and stakeholders.

Specificity: Assesses if the core interventions are specific enough that are focusing to address one particular issue about fee waiver scheme.

Relevance: Assesses the importance of the strategic objectives and or the core interventions to address the objectives of fee waiver scheme.

Applicability: Evaluates the easiness and affordability of the strategic objectives and core interventions to be implemented at the ground level.

Impact: Assesses the possibility of the strategic objectives and core interventions to bring positive outcome .

Table 4.10 Theme Five, Categories and subcategories development structures

Categories	Description	Relevance	Applicability	Impact	Mean
Theme 1	**Ecological context**				
SO 1.1	Ensure program design based on contextual evidences	100	84	100	94.7
Theme 2	**Population coverage**				
SO 2.1	Improve Stakeholders engagement and management system	96	80	96	90.7
SO 2.2	Standardize the implementation approaches and procedures	100	88	96	94.7
Theme 3	**Services coverage**				
SO 3.1	Improve health facilities capacity to provide comprehensive services	100	92	100	97.3
Theme 4	**Performance management**				
SO 4.1	Improve the Monitoring, Evaluation, Accountability and evidence based decision making systems	96	88	96	93.3
Theme 5	**Leadership**				
SO5.1	Improve political commitment, governance and multi-stakeholder coordination systems	100	88	100	96.0

The above table shows the validation scores of the strategic objectives by the five experts based on the listed criteria. Each strategic objective was assessed against the three major validating criteria scored by five experts. Each strategic objectives and critera were measured out of 75% and 25% respectively. However, these score were later on converted in to 100% to ease the understanding and interpretations.

According to the mean score of the experts, all strategic objectives were found valid and scored more than 90%. However, it was also revealed that the applicability of the first strategic objective, Ensure the program design to be based on contextual evidences, was scored less than the agreed cut off point. Based on the experts' opinion, the existing trend for program design and implementation is based on the directions from the upper level political leaders than using the ground level evidences. Hence, bringing such culture will not be an easily applicable task.

Table 4.11 Validation result for Prioritized core interventions

Categories	Description	Clarity	Specificity	Relevance	Applicability	Impact	Average
SO 1	Ensure program design based on contextual evidences						
Intervention 1.1	Conduct feasibility assessments to identify contextual demands, problems and opportunities	92	96	100	92	96	95.2
Intervention 1.2	Generate evidences for the design of the program	96	92	96	88	96	93.6
Intervention 1.3	Pilot the program design in small areas	92	88	92	100	92	92.8
Intervention 1.4	Develop the program design based on contextual evidences	96	96	100	96	100	97.6
SO 2	Improve Stakeholders engagement and management system						
Intervention 2.1	Conduct stakeholders mapping and analysis	96	96	96	96	92	95.2
Intervention 2.2	Design protocol for stakeholder engagement and management	100	100	100	92	88	96
SO 3.	Ensure Standardization of the implementation approaches and procedures						
Intervention 3.1	Revise the implementation manual and procedures	92	88	92	100	96	93.6
Intervention 3.2	Design standardized beneficiaries screening protocol	100	100	100	100	100	100
Intervention 3.3	Strengthening capacities of beneficiaries screening committees at all levels	92	92	100	92	96	94.4
Intervention 3.4	Strengthening capacity of the implementing stakeholders	92	92	100	96	88	93.6
Intervention 3.5	Develop advocacy and promotion procedures	88	88	96	92	92	91.2
Intervention 3.6	Design ownership and accountability enhancing systems	88	88	96	92	92	91.2
SO 4	Improve health facilities capacity to provide comprehensive services						
Intervention 4.1	Develop medical equipment's and supplies management protocol	84	84	88	96	96	89.6
Intervention 4.2	Equip heath facilities with adequate staffs and necessary materials	92	92	100	100	100	96.8
Intervention 4.3	Improve management and governance of health facilities	92	92	96	100	100	96
Intervention 4.4	Develop capacity building and benefit packages for health care providers	92	92	100	84	84	90.4
Intervention 4.5	Assess the feasibility of capitation type of payment to prevent delayed reimbursement process.	96	100	100	100	96	98.4
SO 5	Improve monitoring, evaluation, learning, accountability and evidence based decision making systems						

Intervention 5.1	Develop monitoring, evaluation, accountability and evidence based decision making protocol	96	96	96	88	92	93.6
Intervention 5.2	Design result and accountability framework	100	100	96	88	88	94.4
Intervention 5.3	Develop performance management tools	96	100	100	100	96	98.4
Intervention 5.4	Conduct regular performances Monitoring and evaluation events	100	100	100	100	100	100
Intervention 5.5	Strengthen capacity of responsible stakeholders at all levels	92	92	96	92	88	92
Intervention 5.6	Promote evidence based decision making culture	96	100	92	96	92	95.2
SO 6	Improve political commitment, governance and multi-stakeholder coordination systems						
Intervention 6.1	Design Advocacy and promotion systems	100	100	100	88	92	96
Intervention 6.2	Establish effective accountability and performance management system at all levels	100	100	100	88	92	96
Intervention 6.3	Strengthen governance and coordination capacities	96	96	100	88	88	93.6
Intervention 6.4	Revise the financial management process	92	92	92	92	92	92

The above table depicts the validation results of the core interventions that were scored by the experts. According to the validation results, all core interventions were found to be valid when the mean result is taken. However, when the interventions were assessed against particular criteria, the scoring results of two core interventions (described below) under the fourth strategic objective were below the agreed point.

Develop medical equipment and supplies management protocol: according to validation result, the experts were not confident enough to consider this core intervention as valid in terms of clarity and specificity. Based on the experts' opinion, medical equipment and supplies issue is one of the critical problems the health sector in the country is facing. Hence, it was found as a general intervention that could serve as an intervention for any health service improvement programs rather than specific intervention for fee waiver scheme.

Develop capacity building and benefit packages for health care providers: the applicability and impact of this intervention was not convincing to the experts. Designing benefit packages for the health care providers only would not sustainably solve the problems as the problem is multifaceted across all stakeholders, according to the

experts' opinions. Besides, they were not convinced on the possibility of applying this intervention. Separating the capacity building from the benefit package and treating separately was also suggested by some experts.

4.3 OVERVIEW OF THE RESEARCH FINDINGS

Under the first phase of this study, the researcher employed qualitative data analysis tool, Atalsti 7.5, for the data analysis and organized the findings in to six thematic areas, nineteen categories, 42 sub categories and 114 codes. Based on these findings, the researcher developed a preliminary frame work along with validation checklist and developed an implementation framework with six strategic objectives, twenty-seven core interventions and many detail activities.

4.4 CONCLUSION

The study has revealed that the implementation of the fee waiver scheme has been playing a pivotal role in saving lives of significant poor populations. However, its effectiveness in improving health care access to the poor in terms of population coverage, services coverage and financial protection, still remained as critical areas that need special attention from the government.

Lack of comprehensive services at the facilities, unable to address the health needs of street dwellers and people with no kebele ID card, existence of partiality during screening process, and poor financial reimbursement to health facilities were mentioned as among the major gaps that need to be considered seriously. Similarly, poor stakeholders' coordination and management, lack of due attention for the consistent monitoring, and poor governance and decision making by the political leadership were also some of the key challenges that were potentially limiting the successes.

The study has also revealed that there were valuable assets or opportunities that the coordinating body should consider for further improvements in the service delivery process. These opportunities include: existence of aderejajets (volunteer structures at the lower kebele level), existing government program such as health extension programs and CBHI are among others. Based on the findings from phase one, the researcher

under the second phase developed and proposed implementation framework, which was validated by senior professionals who have been directly engaged on the fee waiver scheme implementation.

CHAPER FIVE

PROPOSED IMPLEMENTATION FRAMEWORK

5.1 INTRODUCTION

This chapter introduced fee waiver Implementation framework based on the findings from phase two of the fourth chapter. i.e. analysis of the preliminary frame work validation process. This Implementation framework is meant to address the limitations and challenges revealed during the study in phase one and to improve the health care access for the poor population in Addis Ababa city. Six major preliminary strategic objectives were designed under the implementation framework by the researcher which then validated later on by the purposively selected program managers and coordinators. These strategic objectives were further splitted into core interventions to facilitate the implementation process.

5.2 PURPOSES OF THE IMPLEMENTATION FRAMEWORK

The main purpose of this implementation framework is to serve as an initial guiding framework for the implementing and coordinating stakeholders. This framework is proposed to fill the inconsistent and poor implementation of fee waiver scheme as revealed from this study in phase one. This frame work will not only help implementers and coordinators to guide the implementation process, it will also help them ensure effective monitoring and accountability of all responsible actors under this program.

5.3 BRIEF OVERVIEW OF THE FRAME WORK DEVELOPMENT PROCESS

As clearly described under phase two of chapter four, the finally developed implementation frame work was first initiated by drafting preliminary implementation framework using the themes emerged during phase one as foundations. Then, a validation checklist and criteria were developed by the researcher in two categories; the strategies and core interventions which were validated separately using five points Likert scales ranging from very high to very low through a delphi technique.

Once the strategic objectives were found valid based on the criteria, then the experts went further in to validating the core interventions under each SOs. Consequently, the researcher analyzed the findings and proposed them as strategic objectives and core interventions of the implementation framework.

According to the experts' agreement, the strategic objectives and core intervention with mean score above 85% were taken as acceptable and valid. Objectives and interventions that scored less than the agreed cutoff point were listed and described in chapter four, phase two analysis part. Similarly, the validation checklist, validation criteria and participants' scores are depicted under the second phase of chapter four.

5.4 DESCRIPTION OF THE FEE WAIVER SCHEME IMPLEMENTATION FRAMEWORK

Based on the findings from chapter four, the detail components of the fee waiver scheme implementation framework are described as follows.

Table 5.1 Themes, strategic objectives and core Interventions

Themes	Strategic objectives	Core interventions
Ecological context	Ensure program design based on contextual evidences	▪ Conduct feasibility assessments and identify contextual demands, problems and opportunities ▪ Generate evidences for the design of the program ▪ Pilot the program design in small areas ▪ Develop the program design based on contextual evidences
Population coverage	Improve Stakeholders engagement and management system	▪ Conduct stakeholders mapping and analysis ▪ Design protocol for stakeholder engagement and management
	Standardize the implementation approaches and procedures	▪ Revise the implementation manual and procedures ▪ Design standardized screening protocol ▪ Strengthening screening committees at all levels ▪ Strengthening capacity of the implementing stakeholders ▪ Develop advocacy and promotion procedures ▪ Create ownership and accountability systems
Services coverage	Improve health facilities capacity to provide comprehensive services	▪ Develop medical equipment and supplies management protocol ▪ Equip heath centers with adequate staffs and necessary materials ▪ Improve management and governance of health facilities ▪ Develop capacity building and benefit packages for health care providers ▪ Assess the feasibility of capitation type of payment to prevent the delayed reimbursement process.
Performance management	Improve the Monitoring, Evaluation, Accountability and evidence based	▪ Develop monitoring, evaluation, accountability and evidence based decision making protocol ▪ Design result and accountability framework ▪ Develop performance management tools

	decision making systems	▪ Conduct regular performances Monitoring and evaluation events ▪ Improve capacity of responsible stakeholders at all levels ▪ Improve evidence based decision making culture
Leadership	Improve political commitment, governance and multi-stakeholder coordination systems	▪ Advocacy and promotion ▪ Establish effective accountability and performance management system at all levels ▪ Improve governance and coordination capacities ▪ Revise the financial management process

5.4.1 Strategic Objective I: Ensure program design based on contextual evidences

This strategy mainly focused on making sure that the program design is based on the existing situations of the context. Various unique characteristics of the city such as geography, demography and infrastructures need to be wisely considered before implementing the design. Besides, the demands of the community, the existing values, opportunities and resources and the threats or challenges that can inhibit the implementation of the fee waiver scheme in the context need to be also intensively assessed. Then, to make sure that the feasibility works best, the design and implementation process need to be piloted in small areas before its full implementation.

According to this study, the program design was implemented simply without considering the real demographic demand and existing infrastructures on the ground. Hence, lack of addressing the street dwellers issue, poor management of people with no kebele ID and unable to balance the demand and supply of the services were the profound findings.

Therefore, the main purpose of this strategy is to ensure that the program design is built based on the contextual evidences and facts. The major action items that could potentially improve this strategy are listed below as follows.

5.4.1.1 Core interventions

5.4.1.1.1 Conduct feasibility assessments

- Investigate the needs, demands, feelings and attitudes of the community towards the fee waiver implementation
- Explore enabling factors and opportunities that can be utilized to accelerate the fee waiver scheme implementation
- Assess the existing challenges, problems and threats that could later holdback the implementation of the scheme.

5.4.1.1.2 Pilot the program design and implementation in small areas

- Synthesize the assessment and the pilot findings

5.4.1.1.3 Develop the program design based on the contextual evidences

- Clearly show the opportunities, challenges and risk management strategies

5.4.2 Strategic Objective II: Improve stakeholders' engagement and management system

The intention of this Strategic Objective is to tackle the poor approaches that have been implemented to manage and engage stakeholders as revealed during this study. The implementation of fee waiver scheme demands collaboration and integration of various direct and indirect stakeholders so as to succeed in achieving its intended objective.

However, this study revealed that the stakeholders' management and engagement process was found to be weak and loose that in turn affected the effectiveness in terms of population coverage. The approach of integrating these stakeholders, their respective roles and responsibilities and their accountabilities were not clearly stated and

communicated. Besides, there were no formal communication meanness and structures that connected them with the coordinating bodies.

Hence, the purpose of this strategic objective is to improve the stakeholders' management and engagement approaches through the development of effective protocols that contain the structures and managements components. The major activities that need be implemented for the achievement for this strategy are listed as follows.

5.4.2.1 Core interventions

5.4.2.1.1 Conduct stakeholders mapping and analysis

- Identify potential stakeholders (Direct and Indirect)
- Conduct stakeholders' analysis (analyze their interests, capabilities and their center of influence).

5.4.2.1.2 Design stakeholders' management and engagement protocol

- Establish exhaustive list of roles and responsibilities of all stakeholders including the coordinating bodies
- Show capacity building procedures
- State clear accountability procedures
- Establish communication procedures and approaches

5.4.3 Strategic Objective III: Standardize the implementation procedures and approaches

This strategic objective mainly focused on the standardization of the overall implementation and beneficiaries screening process of fee waiver scheme. The overall fee waiver implementation process includes the approaches, procedures and governances required to deliver the expected results. Based on this study, the implementation and screening approaches and procedures were not consistent across different woredas and sub cities. The implementing stakeholders at all levels did not adhere to the implementation manual and criteria. Lack of trust on the implementation

manuals, un standardized screening approach, non-comprehensiveness of the implementation manual, poor capacity of the implementing staffs and the community screening committee, poor functionality of the screening committees at all levels, and lack of proper monitoring and evaluation approaches were the major findings revealed during the study.

Hence, this strategic objective is envisaging in standardizing and updating the implementation manual and the screening approaches to improve the effectiveness of the scheme. The major activities that could improve this strategy are prioritized as follows.

5.4.3.1 Core interventions

5.4.3.1.1 Revise the implementation manual and procedures

- Organize consultative workshops with all responsible stakeholders and incorporate their opinions
- Distribute the manual to all stakeholders and implementers

5.4.3.1.2 Design standardized screening protocol

5.4.3.1.3 Strengthening screening committees at all levels

5.4.3.1.4 Strengthening capacity of the implementing stakeholders

5.4.3.1.5 Develop advocacy and promotion procedures.

5.4.3.1.6 Create ownership and accountability systems.

5.4.4 Strategic objective IV: Improve health facilities capacity to provide comprehensive services

According to the implementation manual, citizens should not be denied health services due to financial problems. However, this research finding revealed that the service coverage among the fee waiver beneficiaries was very low that beneficiaries didnt

access the intended health services in public health facilities. Lack of drugs, reagents, medical equipment and poor physical infrastructures were investigated during the study. Poor commitment of the health facilities' management and lack of financial resources have contributed for the poor facilities infrastructures which in turn caused the compromised services coverage among the fee waiver beneficiaries.

Therefore, this strategic objective is intended to ensure that every poor household or individual is getting comprehensive health care services regardless of his/her economic statuses. Hence, capacitating the health facilities in terms of human resources, equipment and supplies are the key interventions this strategy should address. Core interventions are listed as follows.

5.4.4.1 Core interventions

5.4.4.1.1 Develop medical equipment and supplies management protocol

- Proactive forecasting and procurement of necessary drugs, reagents and supplies

5.4.4.1.2 Equip heath centers with adequate staffs and necessary materials

- Lowering advanced diagnostic services to the health centers level
- Assign medical doctors, anesthetists and radiologists at health centers level

5.4.4.1.3 Improve management and governance of health facilities

- Empower the health facilities management committee to make key decisions
- Strengthen the establishment of separate pharmacy for fee waiver beneficiaries only.
- Create networks among public health facilities
- Establish accountability system for the governing board, management committees, and health care providers.

5.4.4.1.4 Develop capacity building and benefit packages for health care providers

5.4.4.1.5 Assess the feasibility of capitation type of payment to prevent the delayed reimbursement process.

5.4.5 Strategic objective V: Improve the monitoring, evaluation, accountability and evidence based decision making system

This strategic objective focused on overseeing the overall performance management of all stakeholders at all levels. It includes improve performance monitoring, outcome evaluation, ensuring accountability and promoting evidence based decision-makings for the effectiveness of fee waiver scheme. The findings of this study revealed that the monitoring, evaluation, accountability and evidence based decision making system were weak and loose. The scheme lacked overall monitoring and evaluation protocol, and result and accountability framework to show stakeholders the performance measurement indicators, immediate outcomes and long-term impact of the scheme. Besides, lack of routine and regular reporting formats and tools to track regular performances, lack of accountability among stakeholders, and lack of shared vision, goal and objectives of the fee waiver scheme were found as the major findings.

Therefore, the purpose of this strategic objective is to improve the monitoring, evaluation, accountability and evidence based decision-making systems. This system is improved through the establishment of tracking tools, frameworks and protocols that can enable implementers and decision makers clearly observe the effectiveness of the implemented interventions. The major interventions designed under this SO are listed as follows.

5.4.5.1 Core interventions

5.4.5.1.1 Develop monitoring, evaluation, accountability and evidence based decision making protocol

- Create shared understanding of the goal and the core responsibilities of the stakeholders

5.4.5.1.2 Design result and accountability framework

- Identify and approve key performance indicators and their targets for all actors
- Clearly show the reporting frequency, responsible body and the resources required

5.4.5.1.3 Develop performance management tools

- Develop and distribute routine monitoring and reporting tools
- Design a dash board that can show the statuses of Key Performance Indicators (KPI) based on the regular reports.
- Develop feedback provision templates

5.4.5.1.4 Conduct regular performances Monitoring and evaluation events

- Organize regular review meetings
- Conduct on site coaching, mentorships and integrated supportive supervisions
- Provide regular feedback based on tangible evidence and facts

5.4.5.1.5 Improve capacity of implementing and coordinating stakeholders at all levels

- Provide basic and refresher trainings on fee waiver implementation

5.4.5.1.6 Improve evidence based decision making culture at all levels

- Synthesize the evidences on success, opportunities and obstacles of the implementation process at all levels
- Provide the facts and evidences to the table of decision makers and political leaders in a simple ad understandable manner
- Promote the importance of evidences for decision making

5.4.6 Strategic Objective VI: Improve political commitment, governance and multi-stakeholders' coordination

The main focus of this strategic objective is to ensure the political commitment, governance and multi-stakeholder coordination systems for the effective improvement of health care access by the poor society in Addis Ababa city. It is only through the government's high commitment, proper governance and strong decision making practices that the goal of the fee waiver scheme can be achieved. According to the study result, it was revealed that the government was allocating extensive financial resources to woredas for the fee waiver implementation. Besides, with the aim of improving fast decision making culture, the health facilities were made to be led by governing bodies composed of high political leaders in their respective levels.

However, it was found that only allocating resources and assigning governing boards were not enough for the success of the fee waiver scheme. The effectiveness and efficiency of the implementation process have to be monitored and evaluated on regular basis. According to the implementation manual, the woreda, zonal and regional level administrations are responsible for the coordination and management of the fee waiver implementation process. However, it was through the health offices at various levels that the coordination role was being played currently which resulted for the weak and ineffective coordination process of the multi-sectors implementation.

Hence, poorly performing stakeholders were not accountable for what they do and decisions were not made accordingly. Some of the major challenges due to poor governance and coordination include: poor financial reimbursement to health facilities, poor bilateral agreement with health facilities and regions, poor functionality of the

screening committee, prevalence of high inclusion and exclusion errors, lack of inputs and supplies at health facilities and existence of outdated and incomprehensive implementation manuals and screening criteria are among others.

As this role is central for the effectiveness of the scheme through bringing different actors in to one platform to work for common goal, it is critical to establish a system that can ensure these all things. Therefore, this strategy is intended to enhance the improved health care access to the poor through improved political commitment and governance systems and such improved system is brought through the implementation of the following major interventions which are the out puts of this study.

5.4.6.1 Core interventions

5.4.6.1.1 Advocacy and promotion

- Convince the political leaders that to make this scheme among the top political agendas of the government.
- Develop communication and promotion principles

5.4.6.1.2 Establish effective accountability and performance management system at all levels

- Establish clear understanding on the shared goals and design roles, responsibilities and performance indicators for all stakeholders that can contribute for this goal
- Monitor and evaluate the performances of the governing boards in terms of making decisions to solve the persistent challenges of health facilities.
- Design performance based awarding system to encourage implementing stakeholders

5.4.6.1.3 Improve governance and coordination capacities

- Strengthen multi sectorial coordination and management

- Establish a system to ensure bilateral agreement between health facilities and coordinating bodies and between regions.
- Assign full time employees that can manage the implementation and management process.
- Introduce the screening process as part of the committee's job description that should be delivered as a deliverable and Strict follow up for the functionality of Committee

5.4.6.1.4 Revise the financial management process

- Put fee waiver budget separately that can't be used for other services, so that it can be directly paid to health facilities when requested.
- Mobilize additional resources to improve population coverage and services coverage.

5.5 CONCEPTUAL FRAMEWORK

This conceptual frame work is designed to show how the strategic concepts and themes can be integrated in a systematically organized fashion to enhance the understanding and interpretation of the whole program components. It was revealed that the program goal will be achieved through effective integration and alignment of these strategies and interventions

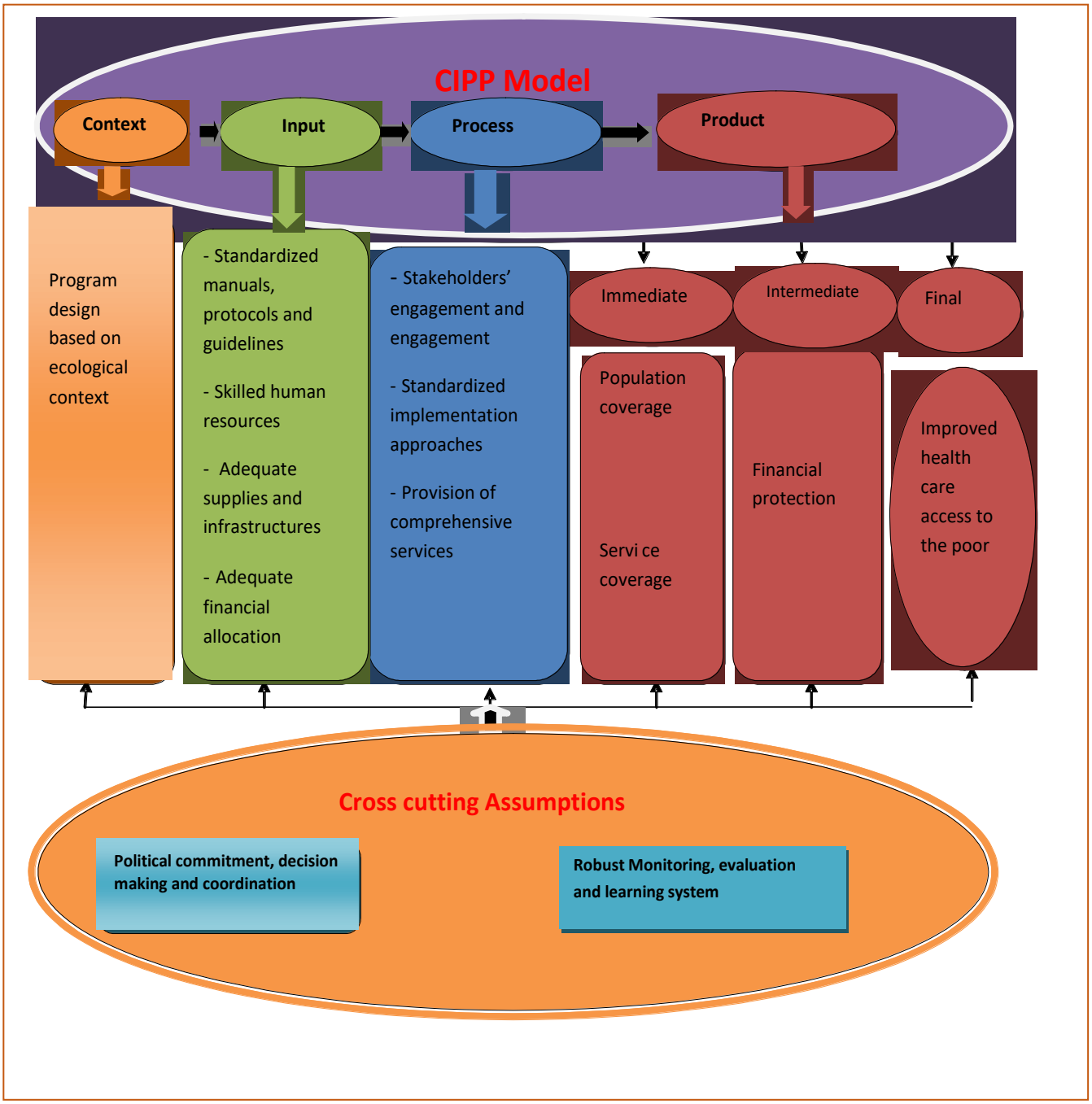

Figure 5.1 Proposed FWS conceptual framework

5.6 CONCLUSION

In general, the main purpose of this chapter was to design an implementation framework for the implementers and coordinators of fee waiver scheme to guide the implementation process in an effective and efficient way. This framework will address the FWS implementation and coordination challenges by providing consistent and comprehensive implementation and governance procedures. This implementation framework was developed based on the finding of the study in phase one. Within the framework, six major strategic objectives and 27 core interventions were designed.

These core interventions are further classified in to major and detail activities that could facilitate the achievements of the intended outcomes. The researcher believes the goal of this scheme will be achieved if these strategic objectives and core interventions are properly implemented and supported. A conceptual framework that could show how the themes and strategic objectives could be aligned and integrated to give the final result was also developed.

CHAPTER SIX

DISCUSSION

6.1 INTRODUCTION

This chapter described the overall findings of phase one in relative to other national and global similar literatures. Following the discussion of each thematic area, the researcher proposed a summary of strategic objectives and core interventions that could address the discovered problems under each theme. These strategic objectives and core interventions were designed and proposed as a result of phase two findings. The detail description of the interventions was well described in chapter five. These strategies and core interventions could potentially address the implementation and coordination challenges that were revealed during phase one. The study findings from phase one were categorized in to six main themes and were described how these affect the effectiveness of the fee waiver implementation. These findings were used as a foundation to develop the fee waiver implementation frame work. The six thematic areas include; ecological context, population coverage, service coverage, financial protection, performance management and leadership through which the findings were described. Various related articles, literatures, policies, guidelines and reports were assessed and used to compare with the findings of this study.

6.2. ECOLOGICAL CONTEXT

The ecological context aimed at assessing the contextual factors that affect the fee waiver scheme implementation either positively or negatively. These factors were mainly categorized in to the need or demand, the existing values or opportunities, and barriers that affect the implementation process. The overall attitude of the society towards the scheme was very positive but too ambitious that most of the populations want free health care services regardless of their economic statuses. This is due to the fact that the cost of health care service at this time was very expensive even for those who were economically better families.

In addition to the demand of the society for free services, of course regardless of their economic status, the number of people who deserve the free waiver scheme (indigents) at the city was also too much when compared with other cities or regional towns. Being the largest metropolitan city in the country, Addis Ababa is a habitant of people with mixed economic status of course with the domination of the poor. Besides, the migration of poor people from all regions to this city on daily basis was adding significant increment to the existing dwellers. Hence, such significant number of poor dwellers in the city raised the demand of the services radically.

Looking on the existing opportunities in the environment, availability of public pharmacies in city was one golden opportunity. Kenema pharmacy is a public pharmacy in the city thatis providing pharmaceutical service to the population with low cost. Zewditu hospital, which serves almost 700 patients a day has created partnership with this pharmacy and opened a mini pharmacy within the hospital to serve only paying patients. Meanwhile, the hospital pharmacy only serves the fee waiver beneficiaries. Hence, this was a good opportunity for the health care facilities to benchmark and adapt in to their own setup.

Besides, the existing of Community Based Health programs were found as valuable opportunities for the implementation of fee waiver scheme. Health extension program and Community Based Health Insurance (CBHI) were among the programs that positively contributed for fee waiver scheme implementation. Since the health extension workers are members of the community screening committees, they conduct regular visiting of households and played a critical role in identifying the poor households in the community. Similarly, the CBHI was piloted in ten woredas. When it is fully implemented, it is expected that the fee waiver beneficiaries will be transferred to this in which their cost will be covered by the government as is done currently. According to the participants, most of the existing challenges such as lack of drugs and biased screening issues will be solved when the CBHI starts.

Existence of organized community volunteers (Aderejajets) had also significant role in improving the fee waiver scheme implementations. It was found in another study that engaging citizens in implementation of pro poor universal health coverage at various points greatly benefits the program (WHO 2014:22). According to this study, there were organized volunteer community members that were responsible for various activities at

the community level. These volunteers serve as mediators between the community and the government institutions through providing information about the community. The main responsibilities of the volunteers include facilitate multi-sectorial missions such as maintain security, facilitate and promote environmental hygiene, screening vulnerable for various benefits including fee waiver beneficiaries and tracing unemployed people to facilitate employment opportunities.

In this study, the community volunteers were found to be the key actors of the waiver implementation in terms of screening the poor in the community. The introduction of community participation as an external accountability strategy in planning, resources allocation, implementation and monitoring of public health activities in Nigeria has also confirmed the considerable role of the community (Uzochukwu, Onwujekwe, Mbachu, Okeke, Molyneux & Gilson2018:5).

The government's commitment to improve the effectiveness and efficiency of health care delivery was also one of the main opportunities for the scheme. According to the manual and regulation for health care financing, establishing governing board for all health care facilities was one of the components of health care financing. These governing boards are led by the administrators or equivalent of the respective administration levels and heads of key sectors are members of the board.

The main purpose of these governing boards was to manage, evaluate and support the performances of these health facilities to provide comprehensive and quality services. However, it was noted that their influencing powers were not well catalyzed and utilized to solve the persistent challenges.

Finally, though the initiation of the CBHI is an opportunity for the waiver implementation, its delayed expansion was found as an ecological challenge. It has affected the FWS implementation negatively. The fee waiver implementation processes were delayed as more attention was given to the CBHI piloting and expansion at the expense of the waiver implementation. Similarly, the complex nature of the city was also found as one inhibiting factor during the FWS implementation. Participants suggested the need to have unique implementation framework for the city in order to manage the FWs implementation effectively.

6.2.1 Strategy: Ensure program design based on contextual evidences

The findings of this study revealed that the program design was implemented simply without considering the real demographic demand and existing infrastructures on the ground. Therefore, the main purpose of this strategy is to ensure that the program design is built based on the contextual evidences and facts.

Hence, the researcher come up with this strategic objective to address investigated problems. The core interventions that are believed to potentially address the existing problems under this strategic objective include:

- Conduct feasibility assessments,
- Pilot the program design and implementation in small areas and
- Develop the program design based on the contextual evidences.

These core interventions are further unpacked in to detail activities under chapter five. It is through these detail activities that the core interventions are translated in to practical implementation to address the problems.

6.3 POPULATION COVERAGE

According to the health care financing regulation and implementation manual, indigent (the poorest of the poor) households and individuals were expected to be included in this fee waiver scheme. To properly screen these households and individuals, objective and clear screening criteria and well trained task forces who can accomplish the process were needed. According to the finding, the fee waiver scheme was found to be one of the successful government led programs. It enabled considerable indigents to access health care, though it has its own limitations. Most participants agreed that indigents that have kebele ID card were well covered by the scheme. In some woredas, more than 35% of the woreda populations were included in the scheme, though it was agreed to screen up to 10% of their population.

On the other hand, it was also found that there were indigents with kebele ID that were not included in the waiver scheme. When health care providers visit households for outreach services, they reported that there were many poor people that were sick and slept at home due to lack of money for treatment. Recent study from Zambia also found that 10% of population that do not seek health care was due to their feeling of expensiveness of user fees at health care facilities; though the primary health care was free (Masiye, Kaonga &Kirigia 2016: 13). Some patients also visit health care facilities after their health status get worsened as they stayed untreated until they get money from different sources.

Many people especially those elders with no care givers had no any information about the free service and as a result, they remained at home. Poor promotion of the scheme across all corners was reported as the main reason for such poor population coverage. Delivering apparent information about the free service to the community was very essential especially for the poor and vulnerable to utilize the service (WHO 2014:45, Masiye et al 2016:13). The responsible government bodies should advocate the lower administrative levels to take care of inclusion and exclusion errors during the beneficiaries' selection process (EHSFR/HFG 2016:50).

The promotion process used various platforms such as house to house visit, community day events, posters, brochures daily teaching at health centers and using the government structures and community volunteers at all levels. Besides, utilizing health extension workers as a key vehicle for the information transmission was found as one of the most effective meanness to address the hard to reach households and communities. However, it was also found that extensive promotions using such platforms were considered as threats as these increase the numbers of beneficiaries and make it unmanageable to the woredas.

On the other hand, most of the study participants agreed that indigents that had no kebele ID, street dwellers and peoples with some kind of disability including psychiatric patients were suffering from lack of access to health care services. Lack of clarity in the implementation manual, poor coordination to manage such vulnerable and lack of special attention by the coordination body were pointed as the major causing factors to inhibit these people from accessing health care. The finding revealed that lack of knowledge

and skills in implementing the fee waiver scheme was widely seen among the office managers, health care providers, stakeholders and community level screening committees.

Apart from the provision of general sensitization training on health care financing is for limited health care providers and woreda health office managers on irregular basis, formal training focusing on specific fee waiver scheme implementation and management has never been given to implementers and stakeholders. Poor compliance with the implementation rules, lack of clear understanding on the eligibility criteria and reluctant of health care providers to provide fee waiver were also mentioned as factors that affected the population coverage (Mathauer, Mathivet&Kutzin2017: 1).

A recent study from Burkinafaso also showed the existence of considerable gap between distribution of directives and practically applying the knowledge in the directives (Ridde, Leppert, Hien, Robyn &Deallegri2018:11). Besides, lack of implementation manual at all levels was also found to be a big problem for the implementers. Hence, stakeholders performed their regular duties through try and error and learned the process in such ways. This in turn caused various implementation problems including unfair selection of beneficiaries.

The other factor that affected the population coverage was the approach that the potential beneficiaries have been screened. Though the screening process was expected to be done by committees at all levels, the committee's poor functionality and some subjective judgments within the committee had influenced the population coverage. The screening process at the woreda level has been done only by the woreda health office which might have contributed for the compromised effectiveness and efficiency of the scheme as un deserving people were included in the scheme at the expense of the deserving people.

According to this research finding, lack of fairness during screening was one of the major challenges during the fee waiver scheme implementation. Rich and non-deserving people who own modern houses and vehicles were utilizing the service for free at the expenses of the lives of the poor in the community.

It was found that Diasporas (people who live outside of the country but come to their country for various reasons) were utilizing the services. It is believed that these people are expected to be modern and rich in relative to the poor society in the country. Similarly, though Ghana's national Health insurance system is a pro-poor policy that fosters equity in access to health care services, a study result challenged the underlying assumption that the scheme significantly benefitted the relatively prosperous peoples compared to the poor people's (Akazili, et al 2014:6).

Embracing the relatively rich people in the beneficiaries list was directly affecting the availability of drugs and supplies in health facilities especially in facilities that have separate pharmacies for fee waiver beneficiaries. Besides, it also raised equity concern in the remaining peoples who were denied from the service due to the screening criteria.

In addition, lack of strict renewal process was also found as a major limitation of the screening committees and the coordinating bodies. The waiver beneficiary certificate serves only for one year when once given and it is expected to be renewed on annual basis. As there might be progresses in economic status and relocation from places to places while renewing, rigorous assessment and investigation was required as during the renewal processes. However, once the beneficiaries were issued the certificate for the first time, they were not longer checked during the consecutive renewal times. They simply go to the woreda health office and got the renewal stamp without any verification.

Partiality of the screening committee members, poor monitoring and evaluation activities and lack of objective and comprehensive screening criteria were also mentioned as causes for the unfair selection process. The screening criteria in the implementation manual were not exhaustively listed and were not explicit. The manual gives the lower and middle level offices as initial guide that will be clearly identified and revised by the woredas and sub cities depending on their respective contexts.

However, letting woredas and sub cities to modify the criteria has potentially caused subjective decisions during screening process and has brought inconsistent criteria among all sub cities and woredas. For example, some woredas included chronic patients in to the scheme regardless of their economic status and some woredas exclude these people as they only see the income level of the applicants. In addition to compromising

the lives of the poor, implementing the criteria based on the willingness and perspectives of the people caused in equity among the beneficiaries and in efficiency in resources utilization.

This finding was similar to the study conducted in Tanzania where screening criteria were inconsistently applied and that in turn created confusions and variations in implementing the pro poor exemption policy (Maluka 2013:4). Nonetheless, “Clarity on the target population, well-chosen effective and efficient eligibility criteria matching the program content, and application of an independent eligibility verification system were among the success factors for targeting” (Rahman & Wazd 2018:13). Failure of the central government in taking the responsibility to address the confusions in eligibility criteria compounded with limited technical support might have exacerbated the problems and contributed to variations of the pro poor policies among districts (Maluka 2013:6).

Similarly, lack of updating the screening criteria in regular basis was also found as a reason for poor adherence to the implementation manual. The manual states the minimum government salary scale as one reference point for setting the screening criteria. However, depending on the current economic inflation and high cost of livings, the minimum standard set was not feasible and applicable in the real situations that even people with better economic status couldn’t afford health service these days.

On the contrary, there were also participants who argued the screening processes were absolutely fair. According to these participants, the availability of various committees at all levels and engagement of the community on the selection process were mechanisms to prevent inclusion and exclusion errors. Besides, posting the list of potential candidates at various public areas for the critics by the community also ensured the fairness of the implementation. They believe, the committees at different levels were serving the deserving indigent populations in a proper and fair manner to improve the population coverage in the city.

Likewise, most participants agreed that the screening committee also allow the poor to get health services if the candidates get sick while they are on the screening process. The woreda health offices provide them with temporary certificate that can be valid for

three months. Then, health facilities can provide adequate service to the candidate beneficiaries using this transitional certificate.

When assessing the community role on the fee waiver implementation, itwas found that the community was one of the key stakeholders that have significant influence on the success of the scheme. The community based screening have been effective in serving as a source of information about the status of the households and also played pivotal role in ensuring fairness during beneficiaries' selection process.

However, a study conducted in Burkina Faso urban settings showed a mixed finding that the community based targeting was effective in some districts respecting the targeting rules without any risks of collusions, and in another urban districts, it was not found suitable to identify the poor households (Ridde et al 2014:7-8). Hence, making targeting mechanisms mutually exclusive; applying various targeting mechanisms at the same time were recommended instead of relying in one method especially in reducing inclusion errors (Rahman et al 2018:13).

In addition to serving as sources of information, it was found that the communities contribute money for those who were not members of the fee waiver beneficiary and for those who lacked money to purchase drugs from private pharmacies. Hence, empowering and engaging the communities in key activities and decisions were found as critical concern.

On the other hand, there were people who don't want their name be posted on public areas for further critics by the nearby dwellers. Based on the participants' opinion, this could be due to lack of confidence on the candidates' possibility of being selected. They might fear that they will be rejected from the list if the public revealed their economic status. If this is the case, the researcher found this mechanism (posting the list in public areas) is meeting its purpose of preventing unfair selections.

The other factor affecting the population coverage was the poor cooperation and alignment of implementing sectors. According to the regulation and implementation manual, labor and social affairs and women and children affairs are the key implementing sectors expected to identify, register, screening, issuing certificates and managing the overall processes or their respective vulnerable groups.

The vulnerable groups include street dwellers, homeless individuals, disabled and psychiatric people, elder people and children with no care givers etc. Nonetheless, when looking at their practical implementation, these sectors were not performing their responsibilities, especially on the management of street dwellers. In some instances, it was found that the labor and social affairs office is duplicating what the woreda administration also works, i.e. serving the beneficiaries who have ID card.

Apart from this, it was found that the labor and social affairs office don't even know the existence of such fee waiver scheme let alone participating in the implementation process. Similarly, the women and children affairs offices were not actively participating in the implementation of the scheme. This is similar to a study conducted in Ghana that showed the poor participation of women and children office and unable to fulfilling their role effectively due to lack of resources (Witter, Garshong & Ridde 2013:5).

As a result, health care providers were getting frustrated due to lack of proper management of such vulnerable. They (Health care providers) repeatedly complained that the responsible implementing stakeholders and the coordinating need to take their responsibilities appropriately so that the aim of the scheme can be archived.

6.3.1 Strategy: Improve stakeholders' engagement and management system

The implementation of fee waiver scheme demands collaboration and integration of various direct and indirect stakeholders so as to succeed in achieving its intended objective. According to this study, the stakeholders' management and engagement process was found to be weak and loose that affected the effectiveness in terms of population coverage. Hence, the purpose of this strategic objective is to improve the stakeholders' management and engagement approaches through the development of effective protocols that contain the structures and managements components. The core interventions that need be implemented for the achievement for this strategy include; Stakeholders mapping and analysis and design stakeholders' management and engagement protocol.

6.3.2 Strategy: Standardizing the fee waiver implementation procedures and approaches

This strategy was designed to address the problems under the population coverage thematic area. It mainly focused on the standardization of the overall implementation and beneficiaries screening process. The implementing stakeholders at all levels did not adhere to the implementation manual and criteria due to lack of trust on the implementation manuals, un standardized screening approach, and non-comprehensiveness of the implementation manual.

Hence, this strategic objective is envisaging to standardize and update the implementation manual and the screening approaches to improve the effectiveness of the scheme. The core interventions that would improve this strategy include:

- Revise the implementation manual and procedures,
- Design standardized screening protocol,
- Strengthening screening committees at all levels,
- Strengthening capacity of the implementing stakeholders,
- Develop advocacy and promotion procedures and create ownership and accountability systems.

These core interventions are further unpacked in to detail activities under chapter five. These detail activities translate the core interventions in to practical implementation to address the mentioned problems.

6.4 SERVICES COVERAGE

The other very important objective of this study was to assess the services coverage status for the beneficiaries. Effective services coverage is defined as the proportion of peoples in need of services who receive services of sufficient quality to obtain potential health gains (WHO & World Bank 2017:2).

This thematic area assessed the ability of the fee waiver scheme to allow comprehensive, quality and advanced Health care services to the beneficiaries free of any payment. This service coverage can be compromised either intentionally by limiting the types and scopes of the services or unintentionally due to lack of capacity of the health facilities and poor performance management and coordination ability of the coordinating bodies.

According to the implementation manual, the fee waiver beneficiaries should be provided with full and comprehensive health care services regardless of their ability to pay. This study finding revealed that there was no any intentional service limit for these waiver beneficiaries. Beneficiaries were provided with whatever the facility was capable of delivering. When the desired services were not available in health centers, they (health facilities) send the beneficiaries to hospitals through referral services.

However, the major problems that inhibited the achievement of services coverage were poor capacity of the health facilities and poor coordination and management of the coordinating bodies. The factors that affected the services coverage mainly include lack of drugs and supplies, shortages of skilled manpower, and poor governance issues were among others.

According to the findings, most patients and implementers stated that the most expensive component of the health service delivery was the price of drugs especially for chronic cases and some diagnostic services. Nonetheless, the most prominent challenging issues in health facilities were lack of drugs and diagnostic services, which in turn were major barriers for the poor to access health care. Hence, some participants

disagree with the statement that says the government was providing service for the poor people for free.

The frequent drugs stock out in public facilities has inhibited the implementation of pro poor schemes (Maluka 2013:5). The indigents who were assumed to access drugs for free were either forced to buy drugs from private pharmacies at the expense of their family's basic needs or they enforced these individuals to forgo the treatment, as these beneficiaries can't afford to buy drugs from these private pharmacies. Therefore, if the so called poor people were forced to buy these costly services from their pocket, the beneficiaries doubt on whether to say the scheme was established to help the poor or not.

According to some participants' opinion, they preferred not to be named as "fee waiver beneficiaries", as they were covering majority of the cost for their medical care at the expense of their children basic needs such as foods and daily consumables and even some of them couldn't buy the drugs due to financial difficulty. The researcher also noted that the most unavailable drugs in the public facilities were the drugs that were very expensive such as chronic diseases drugs, in spite they were very critical and their absence can cause sudden deaths.

On the other hand, the researcher found that there was also a very promising initiative to solve shortage of drugs. Some health facilities have started availing drugs in separate pharmacies only for fee waiver beneficiaries. These were health facilities that have very high patient loads where drugs get finished easily unless separately managed for fee waiver beneficiaries. This was done by committing agreement with public pharmacies which demands the willingness of both parties and the coordinating bodies.

The other factor that negatively affected the service coverage was lack of equipment and machines at health facilities. Similarly, a finding from ten countries (Leslie, Spigelman, Zhoub & Kruka 2017: 745) showed that 8.9 % of health facilities lacked one or more of the most basic rapid diagnostic tests. Lack of medical equipment such as x-ray, ultrasound and some laboratory machines at health centers was found to be the major barrier to access health care by the poor society.

Though patients were referred to hospitals to get such services, these machines were found non-functional even at these hospitals. As a result, the poor patients were forced either to forgo the treatment due to financial difficulties or got in to debt to purchase the services at the expense of their families basic needs. Hence, most beneficiaries don't want to visit hospitals as there was no better care than the health centers. Rather, the hospitals were said to be more complicated services areas. Therefore, beneficiaries were forced to go to private clinics to buy the services at the expenses of compromising their basic needs. Out of Pocket expenditures for health care create financial difficulties for some households and push others in to poverty (Kimani & Maina 2015:11). Direct out of pocket expenditure at the time of care are identified as the single biggest barrier to health care access (Kimani, Mugo & Kioko 2016:449).

Apart from the drugs and medical equipment, health centers were also suffering from lack of skilled and senior professionals such as medical doctors and radiologists. The main reason was shortage of these professionals at national level and even hospitals were facing the same problems. Thus, the government need to give prior attention to avail both equipment and senior professionals in parallel as availing either of these couldn't solve the problems.

When explored for any service variation between the beneficiaries and the paying patients, mixed opinions were found from the implementers and waiver beneficiaries. The waiver beneficiaries believe they were discriminated due to the fact that they were not directly bringing cash to the facilities. They believe priority was given for the paying patients especially in terms of drugs provision and availability of some test reagents.

A study from Ghana also reinforced this concern that the poor included in the pro poor policy were discriminated as they don't directly pay for the services (Dalinjong&Laar2012:8). Paolo and Paredes (2016:7) also underlined this issue that provision of equal treatment for the scheme beneficiaries and for the paying patients is not yet achieved as that in equities in the health care utilization remained pro rich.

However, the perspective from the implementers and managers were different from this. According to them, there was no any condition that the beneficiaries could be less prioritized. They suggested that the health care providers are blind of the patients'

statuses; they don't have any information about who is paying and who is waiver beneficiary. Therefore, according to the health care providers' conclusion, all patients were served equally without any discrimination. According them, the beneficiaries complain comes when they were told that drugs were not available. They assume it as if it was done intentionally.

Contrary to the beneficiaries thought, the study revealed that health care providers were sacrificing to serve these patients in various ways. When diagnostic services such as x-ray and ultrasound services or drugs were not available in the facility, the fate of these poor people will be either going back home to sleep without any care or to compromise their daily basic needs and buy the services. During such instances, Health care providers communicate with the facilities around ten sub cities and bring those drugs as a loan from facilities with les patient load.

Similarly, the staffs manage such difficult situations through contribution of money for the patients to buy drugs or other diagnostic service from private organizations. If the contributed money was still not enough for the treatment, the health care providers negotiate with the private organizations through letter or telephone and beg the private organizations to serve the patients in a discounted price.

Nonetheless, a study from Zambia shown that informal charging of the health care providers to the poor through selling drugs and receiving bribe to conduct medical test were found to be factors to aggravate the catastrophic expenditure by the poor (Masiye, Kaonga & Kirigia2016:12). A study conducted in Tanzania however, showed that financial incentive was provided to the facility committees and board members and found to be effective in facilitating the pro poor exemption policy (Maluka 2013:5). Likewise, reward systems for performances was recommended to motivate performers as poor motivation of the staffs were found a reason to enhance the implementation of pro poor health packages (Uzochukwu et al 2018:7).

In addition, the researcher also found that the health care providers also serve the non-emergency cases as emergency. According to the implementation manual, health facilities are obliged to give full health service for people affected by any emergency conditions. However, if patients were not capable of paying or no one was nearby to

support them, the facilities were forced to cover all the costs that will be claimed for reimbursement by the respective administration. This was happening due to the fact that the fee waiver scheme was not addressing all the needy people in the city including the street dwellers. The health care providers were doing their professional responsibilities to save lives of individuals at the expense of the service quality due to serving beyond their plan.

Lack of comprehensive services in the health facilities was one of the major problems beneficiaries were faced with. Though the fee waiver scheme was also intended to improve the financial capacity of facilities through the reimbursed money from the government body, it was not happening as expected. It was found that facility management's poor commitment, lack of budget due poor reimbursement on timely basis, lack of drugs, reagents, machines and skilled professionals were the major reasons that caused for the lack of comprehensive service delivery.

Health facilities delay in requesting the financial reimbursements were also mentioned during the study. According to EHSFR/HFG (2016:50), health facilities should submit all expenditures to the woreda finance office on timely basis. Funding delays that usually took up to five months to reimburse has affected the implementation of the pro poor policies as health facilities are forced to withhold free services (Witter et al 2013:4). This and increased demand for free health care services caused health facilities to be financially deprived (Maluka 2013:5).

According to some respondents, the type of payment system, fee for service, was the reason behind the delayed reimbursements and suggested to make the payment system a capitation type to solve the payment problems. The cost recovery or fee for service types of payment system was assumed to contribute for the weak performance of the pro poor policies as it weakens the financial capacity of health facilities due to delayed reimbursements (Ridde et al 2018:9).

Finally, most study participants suggested that health centers should be fully equipped with skilled human resources, necessary drugs, and equipment's and rehabilitation centers to address the needs of the poor population. Otherwise, promoting the fee waiver

scheme without addressing these issues is only for political consumption with no benefit for the poor.

6.4.1: Strategy: Improve health facilities capacity to provide comprehensive services

This research finding revealed that the service coverage among the fee waiver beneficiaries was very low that beneficiaries didnt access the intended health services in public health facilities. Therefore, the intention of this strategic objective is to ensure that every poor household or individual is getting comprehensive health care services regardless of his/her economic statuses. Capacitating the health facilities in terms of human resources, equipment and supplies are the key interventions this strategy is expected to address. The core interventions under this strategy include:

- Develop medical equipment and supplies management protocol
- Equip heath centers with adequate staffs and necessary materials
- Improve management and governance of health facilities
- Develop capacity building and benefit packages for health care providers
- Assess the feasibility of capitation type of payment to prevent the delayed reimbursement process.

These core interventions are further unpacked in to detail activities under chapter five. These detail activities translate the core interventions in to practical implementation to address the problems.

6.5. FINANCIAL PROTECTION

The Financial protection thematic area examined the status of fee waiver scheme in terms of protecting the beneficiaries from financial impoverishment. Financial protection in health occurs when families who get needed care do not suffer from undue financial hardship as a result of payments made to health services (WHO & World Bank 2017:22). According to the study result, the fee waiver scheme has prevented many poor people from death and from financial impoverishments. Recent study from Zambia also revealed

that free primary health care services have benefitted significant people with free service at the point of use (Masiye et al 2016:13).

As the cost of health care services were getting higher and higher these days, the government's efforts to improve health care access by the poor were found vital, according to participants' opinion. Some participants even called the fee waiver scheme as:

> *"One of the most successful government led program that is practically implemented at the ground".*

However, though it has saved many poor people from death and financial difficulties, it was also found that the scheme couldn't protect the beneficiaries from financial deprivation as expected. This study revealed that the beneficiaries were suffered from financial difficulties as a result of health care payments. A study from Zambia also found that removal of user fees during health care delivery was not a guarantee to secure the financial protection among the poor segments of the population, as the catastrophic expenditure in outpatient visit reached up to 10% of the population (Masiye et al 2016: 12).

Many people facing financial catastrophe sell assets, go into debt, or reduce their consumption of other basic necessities (World Bank 2019:25). Fee waiver beneficiaries were forced to pay for health care services to save their life which in turn led them in to financial trouble and compromised basic needs. For those who are fee waiver beneficiaries, out of pocket expenditure is considerably large to cause severe financial strain on the patients which can be catastrophic and push them in to destitution as they were already poor (WHO 2014:32). Lack of drugs and medical equipment were forcing the poor either to forgo service or to buy the service from private organizations.

Likewise, a study conducted in Zambia explained high incidence of catastrophic expenditure in the poor as the people were referred to the private organizations to buy drugs or medical tests due to lack of these services in the public facilities (Masiye et al 2016: 12). Patients who were included in a pro poor service packages make large out of pocket payments relative to their income which in turn led the household in to

catastrophic conditions (Aryeetey, Wsteneng, Spann, Jehu-Appaiah, Agyepong & Baltussen 2016: 7).

According to some respondents, waiver beneficiaries bought the medicines by passing their dinners and lunches. Correspondingly, the study also found that denying health care service for the sake of children's food and basic needs was common among fee waiver beneficiaries. Parents were scarifying their lives for the survival of their children and family.

The price of the health care services at the private clinics and pharmacies was by far very expensive even for the people with good economic status let alone for the poor of the poor. Therefore, user fees did not only become barrier for poor households to access quality health care, but it also led these households in to welfare loss(Atake2018:8). This calls the government for the special attention to protect the poor from economic crisis due to out of pocket expenditure for un available service at public health facilities.

Poor implementation process of the fee waiver scheme has caused the indigents to face financial difficulty which was contradicting the underline assumption of the scheme. Lack of clarity on the implementation process and poor compliance to the manual has also caused the poor people to face severe financial consequences from out of pocket expenditure or had to forgo the health service (Mathauer, Mathivet & Kutzin 2017:1).

As the implementation process was suffered from various feasibility challenges and non-compliance to exemption rules, pro poor exemption mechanism through direct targeting did not effectively provide financial protection for the indigents (Mathauer et al 2017: 1). In general, poor capacity of the health care facilities to provide comprehensive services and poor leadership and accountability system let the beneficiaries not to get adequate service. As a result, poor people continued to face severe financial consequence from out of pocket expenditure or had to forgo health care service (Mathauer et al 2017: 1).

The researcher believe that the strategies designed to improve the population coverage and services coverage will directly address the problems that are challenging the financial protection of the poor population in the city. Hence, the researcher hasn't designed separate strategy for this thematic area.

6.6 PERFORMANCE MANAGEMENT

Another component that emerged as a thematic area was performance management. This theme mainly assessed the routine and regular monitoring, evaluation, accountability of the scheme. This explored the existence of robust implementation monitoring and evaluation tools and practices to make sure that the implementation process has been in the right track.

Deployment of monitoring and accountability framework was found to be one of the success factors of the implementation process (Rahman & Wazd 2018:13). In order to measure the effectiveness of any program, the program need to have performance monitoring and evaluation frame work. Comprehensive set of performance indicators are key tools for the public to hold the decision makers accountable for what they do in terms of achieving the target (WHO 2014:47).

However, lack of proper monitoring and evaluation practice was one of the poorly practiced components during the waiver implementation. How the implementers and decision makers are accountable both to their role and to the public was not clearly indicated in the implementation manual. Besides, there were no indicators that can measure the performances of the stakeholders.

Some of the major indicators may include but not limited to the existence of the institution that is responsible to generate scientific evidences relevant for priority setting during policy formulation, and participation of key stakeholders in priority setting and decision making activities (WHO 2014:50). Similarly, indicators about service coverage and financial protection together with their distribution across the need population groups were also required to measure the outcome of the fee waiver scheme (WHO 2014:47).

Thus, lack of such comprehensive monitoring, evaluation and accountability system resulted unable to objectively monitor and evaluate the performances of the stakeholders and the outcomes of the implementations. Similarly, a study conducted in Nigeria also stated poor monitoring and evaluation frameworks, and weak governance and

commitment have caused the poor performances in various components of the pro poor reforms (Uzochukwu et al 2018:7).

According to the health care financing implementation manual, health facilities are led by board with expectation of evaluating the facilities every six months. These board members are senior political leaders in various higher posts and are expected to make effective decisions based on evidences. Systemic monitoring and evaluation of the impact of the policy development and implementation on health equities among the poor and other marginalized populations need be considered by these leaders (Health Policy Project 2014:2).

However, this study found that evidences were not regularly and generated and synthesized to be utilized for decision makings. Such critical gaps in the evidence base for health financing hamper action and constrain results (World Bank 2019:49). These board members were not making the implementers and facility management accountable for what they were delivering.

Implementing pro poor community based scheme requires a mechanism through which the public can be participated in decision making activities and to make policy makers and other implementers to be accountable (Global Health 2015:9). Lack of accountability system in this scheme has caused various challenges to persist and effectiveness of the scheme to be compromised.

Lack of consistent drugs and supplies, poor financial reimbursement, biased screening process and existence of subjective screening criteria were among the major concerns found as factors that affected the effective implementation of fee waiver scheme. Had there been effective monitoring and accountability system led by the board leaders, these concerns could have been solved and the poor would have access health care services. So, the participants found it difficult to say the board was functioning up to its expectation in solving the persistent issues of the system.

Despite the fact that effective supervision and special government commitment are the most determinant factors for the successful implementation of pro poor reforms (Maluka 2013:6), it was found that there were no regular performance assessments for routine performance improvement and to generate evidence based decisions. The regional

health bureau was responsible to give technical support to sub cities, and sub cities were responsible to control and support woredas. However, many woredas were complaining for lack of technical and administrative support from sub cities and regional levels.

Lack of adequate budget for review meeting and supervisions were mentioned as signs of poor government attention to monitor the progress. The supportive supervisions and regular assessments were managed and supported by implementing partners that when they phased out no one was taking the responsibilities.

Therefore, in order for the country to achieve the aim of the scheme and to progress towards UHC, designing and implementing comprehensive monitoring, evaluation Accountability and Learning system and advocating the need for evidence based decision makings are the major suggestions forwarded by the study participants. Likewise, WHO (2014:22), also recommended countries to strongly work on this and suggested as: countries should invest in monitoring and evaluating their respective progress and approaches to move towards the achievement of Universal Health Coverage.

6.6.1 Strategy: Improve the monitoring, evaluation, accountability and evidence based decision making system

The findings of this study revealed that the monitoring, evaluation, accountability and evidence based decision making systems were weak and loose. The scheme lacks overall monitoring and evaluation protocol, and result and accountability framework that can show stakeholders the performance measurement indicators, immediate outcomes and long-term impact of the program.

Therefore, the purpose of this strategic objective is to improve the monitoring, evaluation, accountability and evidence based decision-making systems through the establishment of various tools, frameworks and protocols that can enable implementers and decision makers clearly observe the effectiveness of the implemented interventions. The core interventions that could help improve this strategic objective include:

- Develop monitoring, evaluation, accountability and evidence based decision making protocol
- Design result and accountability framework
- Develop performance management tools
- Conduct regular performances Monitoring and evaluation events
- Improve capacity of implementing and coordinating stakeholders at all levels
- Improve evidence based decision making culture at all levels

These core interventions are further unpacked in to detail activities under chapter five. These detail activities translate the core interventions in to practical implementation to address the problems.

6.7 LEADERSHIP AND GOVERNANCE

WHO (2007) defines governance as "ensuring strategic policy frame works exist that are combined with effective oversight, coalition building, provision of appropriate regulations and incentives, attention to system design and accountability."

The Leadership and governance component of this study assessed the performances of the coordinating bodies at all levels, the decisions given to guide the performance in the right direction and the government's political commitment in to achieve the intended objectives. "*First, implementing pro poor Universal Health Coverage is an inherently political process*" (WHO 2014: 22).

"It is impossible to achieve the UHC by 2030 without giving special attention for the funding and evaluating measures of the pro poor packages" (WHO 2014:11). There is wide spread consensus that failures in leadership, governance and /or organizational capacity constrain progress in health financing in many countries (World Bank 2019:46).

The implementation of fee waiver scheme is a multi-sectoral and multi-stakeholders mission that special attention was required from the higher level government bodies for its effectiveness. According to the implementation manual, the sub city and woreda administration offices are the owner and coordinator of the scheme at their respective

administrative levels. The performances of the governance and decision-making are the key determinant factors for both the success and failure of the scheme.

Nonetheless, the finding revealed many implementation gaps and limitations that attributed to poor governance and decision-making. These limitations were hindering the scheme from achieving its intended results. One attribution of the poor governance includes lack of proper monitoring and evaluation framework for the scheme. These implementing stakeholders and even the coordinating bodies were not clear what their respective deliverables and indicators look like. There was no any reference point against which performances will be evaluated later on. Lack of routine assessments, joint supportive supervision and performance evaluation sessions to see the performances of these stakeholders were also found as major gaps that the leadership should have managed. As a result, decisions were made without evidence, which in turn led to program in efficiencies and ineffectiveness.

Lack of clarity and ownership of the program were also revealed during this study. There was no clarity on the shared vision and mission among the implementing stakeholders. These stakeholders were not clear on how the complementarities and inter linkages of stakeholders' performances would improve the health care access by the indigents in the city. Hence, how could one organization actively participate in an area that was not clear enough why and how to perform? This clearly shows the lack of proper coordination and leadership of the coordinating bodies at all levels.

Similarly, capacity problems of the implementing stakeholders were also found as one of the major implementation challenges during the study. Poor understanding of the implementation manual and its procedures were observed among most study participants which in turn caused poor adherence to the implementation manual. Lack of capacity buildings and technical supports to the lower level implementers, absence of the implementation manual at all levels and lack of trust and acceptability to the manual were found as major causes for the poor adherences.

Majority of the implementers also believe that the manual lacks comprehensiveness and was not realistic with the existing situations. The manual developed by the regional health bureau has only generic criteria to be customized by the woredas and then to be

approved by the sub city approval committee. However, woredas customize it without getting approval from the sub cities, which led to setting different screening criteria and subjective judgments across the woredas. Nevertheless, the policy makers and leaders should ensure that all policies, strategies, plans, programs and financing interventions reflect the realities of the poor and other marginalized groups and respond to their needs (Health Policy Project 2014:2).

The other finding in the study was poor decision-making ability by the coordinating body. According to the manual, there need to be bilateral agreement between health facilities and woredas or sub cities, among all regions between regions and federal hospitals. However, according to the study, proper bilateral agreement was not practiced among facilities and administration offices at all levels which in turn caused for the poor financial reimbursement from administration offices to the health facilities.

Lack of timely and appropriate request from health facilities and lack of money at the woreda as the finance and economic offices also utilize the fee waiver budget for other payments during the requested period were among the causes for poor and delayed reimbursement process. And these in turn caused for the compromised quality health services in the facilities. Joint leadership between ministries of finance and ministry of health can accelerate the development and implementation health financing solutions particularly in areas where, despite broad consensus about principles and policies, progress lags (World Bank 2019:9).

The political ownership and commitment was also found to be poor, according to the findings. The political leaders at all levels gave priority to other political agendas and leave this issue to health sectors only. In order to be effective in the implementation of this reform, it needs policy champions at different levels of the system and objectively delineated roles should be designed for all champions (Witter et al 2013:8-9).

Unless some measures are put in place to verify the applications, only launching of policies and regulations doesn’t guarantee the political commitment (Ridde et al 2018:8). As a result, many developing countries will fail to achieve their targets for universal health coverages and the sustainable development goals (World Bank 2019:13).

Finally, as the multi-sectorial nature of the program demands neutral coordinating body for its proper implementation, the leadership and governance need to think of designing separate structure so that the health sector concentrates on the provision of quality services. In addition to the demand for the independent structure to manage the implementation process, health office managers have also found it very difficult to manage such huge activities with the existing staffs. Hence, it is advised to have one full time focal person who can manage the process at least at woreda and sub city health offices.

6.7.1 Strategy: Improve political commitment, governance and multi-stakeholders' coordination

The main focus of this strategic objective is to ensure the political commitment, governance and multi-stakeholder coordination systems for the effective improvement of health care access by the poor society in Addis Ababa city. However, despite the fact that the government was allocating extensive financial resources to woredas for the fee waiver implementation, and health facilities were led by governing bodies composed of high political leaders in their respective levels, these interventions were not effective in solving the persistent problems.

Some of the major challenges attributed to poor governance and coordination include: poor monitoring and evaluation of the effectiveness and efficiency of the implementation process, poor financial reimbursement to health facilities, poor bilateral agreement with health facilities and regions, poor functionality of the screening committee, prevalence of high inclusion and exclusion errors, lack of inputs and supplies at health facilities and existence of outdated and incomprehensive implementation manuals and screening criteria were among others.

As this role is central for the effectiveness of the scheme through bringing different actors in to one platform to work for common goal, it is critical to establish a system that can ensure these all things. Therefore, this strategy is intended to enhance the improved health care access to the poor through improved political commitment and governance systems. To improve such system, the researcher designed the following core interventions.

- Advocacy and promotion
- Establish effective accountability and performance management system at all levels
- Improve governance and coordination capacities
- Revise the financial management process

These core interventions are further unpacked in to detail activities under chapter five. These detail activities translate these core interventions in to practical implementation to address the problems.

6.8 CONCLUSION

This discussion chapter generally explored and described the overall implementation processes and effectiveness of the fee waiver scheme in terms of improving health care access to the poor. The evaluation was done from the perspectives of the waiver beneficiaries and the implementers. The findings were categorized and discussed under six major themes that comprehensively explained the whole components of the scheme.

The three themes, population coverage, service coverage and financial protection were the main outcomes of the fee waiver implementation. While, the remaining three themes, ecological context, performance management and Leadership were categorized as enabling and cross cutting conditions that determined the success or failure of the scheme.

In general, though the commencement of the scheme has benefited considerable indigents in the city, lack of proper implementation and management has affected its effectiveness. Lack of proper integration and coordination, poor lack of comprehensive monitoring and accountability system, poor capacity of health facilities to provide comprehensive services coupled with poor governance and decision-making capacities were the major factors that hindered the effectiveness of the scheme from achieving its intended objectives.

Therefore, unable to include the needy population in to the scheme and the poor service coverage at the health facilities haven't protected the poor from facing financial crisis and impoverishments. Most beneficiaries were engaged in forced purchase of drugs and

services from private organizations at the expense of their families' basic needs. Likewise, most of the beneficiaries were also forced to forgo the treatment and went back home to sleep as they have nothing to pay for the medical services.

Hence, the effectiveness of the scheme was compromised that government has to recheck and improve the implementation and coordination process as clearly pointed in this study. For this effect, the researcher has designed workable implementation framework during the second phase of this study (refer to chapter five). This framework will serve as a comprehensive guide for the implementers and coordinators and it is expected to potentially address the existing implementation and management problems.

CHAPTER SEVEN

CONCLUSSION AND RECOMMENDATIONS

7.1 INTRODUCTION

The conclusion and recommendation chapter summarized the whole components of this study. The research design and method, the key findings of the study, proposed implementation framework, key recommendations, contributions of this study, and limitations observed in this study were covered in this chapter.

7.2 RESEARCH DESIGN AND METHOD

This study was conducted in two phases: Phase one addressed the evaluation of the fee waivers scheme effectiveness in improving health care access for the poor, and phase two managed the development of fee waiver implementation framework.

The first Phase employed qualitative research approach with exploratory and descriptive case study designs to evaluate the effectiveness of the fee waiver scheme from the implementers and beneficiaries' perspectives. Purposive sampling method was used to select the study sites and study participants using inclusive and exclusive criteria. Similarly, convenience sampling technique was also used to include the fee waiver beneficiaries in to the study population during their visit to health facilities. FGD, KII, delphi technique and document review data collection techniques were used. Health care providers, program coordinators at all levels, representatives from implementing stakeholders, community representatives and fee waiver beneficiaries were the key study populations during the study.

The researcher employed Atlas ti 7.5, qualitative data analysis software, to analyze the findings. First, the translated and transcribed interviews (primary documents) were entered in to the data base and these primary documents were read extensively to internalize the meaning and sense of the study participants. Then, the assembled

primary documents disassembled in to various codes which later reassembled in to broader concepts of categories and themes.

Similarly, in the second phase, the researcher initially designed preliminary implementation framework and then this preliminary framework was validated by senior and experienced experts via Delphi techniques. These experts were selected purposively from implementing organizations at federal, regional and woredas levels. Practical experiences and knowledge about the program were the criteria for extracting the experts from these organizations.

A self-administered validation checklist along with validation criteria was developed and shared to the selected study participants together with consent form. Then, these validation findings were analyzed, summarized, described and proposed as implementation framework. The implementation framework comprised six strategic objectives and 27 core interventions. Subsequently, a conceptual framework was also developed and proposed through which the whole sense and concept of the study is summarized.

7.3 SUMMARY AND INTERPRETATIONS OF THE RESEARCH FINDINGS

The overall findings of phase one and phase two were described in a summarized way as follows. The findings were summarized based on the thematic areas,

7.3.1 Ecological Context

The ecological context aimed to assess the contextual factors that affect the fee waiver scheme implementation positively and negatively. These factors were mainly categorized in to need of the society, existing opportunities, and barriers that could negatively affect the implementation process.

Excessive demand for free health services in the city was boldly observed in the city. The living standards of the population and the expensive nature of health care cost these days were found as major reasons for such huge demand. Similarly, availability of public pharmacies in city, existing of community based health programs and existence of

organized community volunteers were found valuable opportunities that positively contributed for the fee waiver scheme implementation.

A study conducted in Nigeria has also confirmed the role of community in a success of any program when engaged in planning, resources allocation, implementation and monitoring of public health activities (Uzochukwu et al 2018:5). The government's commitment to improve the effectiveness and efficiency of health care delivery by making health facilities to be led by governing boards was also among the opportunities for the implementation of the scheme.

The delayed expansion of CBHI, the complex nature of the city, and the poor infrastructures of the health facilities were found as ecological barriers that could slow down the progress of the fee waiver implementation. Though the initiation of the CBHI was an opportunity for the waiver implementation, its delayed expansion has affected the FWS progress negatively as this has been taking the full attention of the political leaders that were responsible to manage the fee waiver scheme.

7.3.2 Population Coverage

According to the health care financing regulation and implementation manual, citizens should not be denied health care services due to financial reasons. Hence, all indigents (the poor of the poor) households and individuals were expected to be included in this fee waiver scheme.

In general, this study revealed the opportunities, progresses and limitations on the areas of implementation, coordination and governance that need to be addressed by the coordinating bodies at all levels. Accordingly, the fee waiver scheme was found to be one of the successful government led programs that considerable indigents were able to access health care free of any payment. Indigents(the poorest of the poor) who have kebele ID card were included in the package as fee waiver beneficiaries. In some woredas, more than 35% of their woreda populations were included in the scheme, despite the fact that the agreement was to screen up to 10% of their population.

On the other hand, significant indigents who had the right to get the services for free were not included in the scheme. As a result, they were suffering from health and

financial crisis. Majority of these poor were people with no information about the scheme, those who had no kebele ID, street dwellers and people with some sort of disabilities or psychiatric problems. Significant numbers of indigents were found sick and slept at home denied health care due to lack of information. Some of them stayed at home until they get money for treatment. Recent study from Zambia also found that 10% of population that do not seek health care was due to their feeling of expensiveness of user fees at health care facilities; though the primary health care was for free (Masiyeet al 2016: 13). Lack of proper promotion due to poor management in one side and fear of increased demand from the other side were the underline causes.

Similarly, the poor people with no kebele ID, the street dwellers and the peoples with disabilities were denied the service due to technical and operational in efficiencies during the program implementation. Lack of clarity in the implementation manual, poor coordination to manage such vulnerable and lack of special attention by the coordination bodies were found as the major causing factors inhibited people from accessing health care. Mathauert et al (2017:1) also found Poor compliance with the implementation rules, lack of clear understanding on the eligibility criteria and reluctant of health care providers to provide fee waiver were also mentioned as factors that affected the population coverage.

On the other hand, the study revealed the existences of rich and undeserving people included in the fee waiver scheme due to biased and un controlled selection process. These people were owners of modern vehicles and house and Diasporas that were utilizing the services at the expenses of the lives of the poor. A study conducted in Ghana also supported this as: though Ghana's national health insurance system is a pro-poor policy that fosters equity in access to health care services, a study result challenged the underlying assumption that the scheme significantly benefitted the relatively prosperous peoples compared to the poor people's (Akazili et al 2014:6).

Lack of consistencies in the implementation of the manuals among woredas, kebeles, and health facilities at different levels were also revealed during the study. Lack of updated, standardized and comprehensive screening criteria that is common for all woredas was the major reason for such inconsistent and subjective judgments during beneficiaries screening process. These subjective judgments have compromised the

lives of the poor, raised in equity concern among the beneficiaries and caused in efficiency in resources utilization. Though the availability of various committees at all levels and engagement of the community on the selection process were appreciated, these were not able to prevent the inclusion and exclusion errors.

This was similar to the study conducted in Tanzania where screening criteria were inconsistently applied and that in turn created confusions and variations in implementing the pro poor exemption policy (Maluka 2013:4). Nonetheless, “Clarity on the target population, well-chosen effective and efficient eligibility criteria matching the program content, and application of an independent eligibility verification system were among the success factors for targeting” (Rahman et al 2018:13).

Loose monitoring and follow up during renewal process was also found as a major limitation of the screening committees and the coordinating bodies. The beneficiaries themselves have confirmed that they were no longer checked during the consecutive renewal periods, once the beneficiaries were issued the certificate for the first time. Partiality of the screening committee members, poor monitoring and evaluation activities and lack of objective and comprehensive screening criteria were described as contributing factors for such poor assessments during this period.

The poor cooperation and alignment of implementing sectors has also found as a contributing cause for the poor population coverage. Though the labor and social affairs and women and children affairs were among the key implementing sectors responsible to identify, register, screening, issuing certificates and managing the overall processes for their respective vulnerable groups, these sectors were not performing their responsibilities. This was similar to a study conducted in Ghana that showed the poor participation of women and children office and unable to fulfilling their role effectively due to lack of resources (Witter et al 2013:5).

Poor coordination and governance system, loose monitoring, evaluation and accountability system, poor capacity of implementing stakeholders, lack of adequate implementation manual at all levels, lack of teamwork and collaboration among the woreda screening committees were the major causes for the poor population coverage. A recent study from

Burkina Faso also showed the existence of considerable gap between distribution of directives and practically applying the knowledge in the directives (Ridde et al 2018:11).

It is the central government's political commitment that determines the success of any program. A study conducted in Tanzania also confirmed this as: failure to do so Failure of the central government in taking the responsibility to address the confusions in eligibility criteria compounded with limited technical support might have exacerbated the problems and contributed to variations of the pro poor policies among districts (Maluka 2013:4).Hence, responsible government bodies should advocate the lower administrative levels to take care of inclusion and exclusion errors during the beneficiaries selection process (EHSFR/HFG 2016:50).

7.3.3 Services Coverage

Services coverage mainly assessed the ability of the fee waiver scheme to allow comprehensive, quality and advanced health care services to the beneficiaries free of any payment. This study finding revealed that there was no any intentional service limit or service denial for these waiver beneficiaries. Beneficiaries were provided services with whatever the facility is capable of delivering and were referred to better health facilities as needed.

However, the major problem that affected the achievement of services coverage was poor capacity of the health facilities and poor coordination and management of the coordinating bodies. Lack of drugs, reagents, medical equipment and skilled professionals in the public health facilities were found the main barriers for the poor services coverage. Most beneficiaries were told to buy drugs and other service from private organizations when visiting the public health facilities.

The frequent drugs stock out in public facilities has inhibited the implementation of pro poor schemes (Maluka 2013:5). The indigents who were assumed to access drugs for free were either forced to buy drugs from private pharmacies at the expense of their family's basic needs or they were enforced to forgo the treatment. According the study, most of the unavailable drugs in the public facilities were the drugs for chronic diseases that were very expensive in spite they are very critical and their absence could cause

sudden deaths. Hence, the beneficiaries doubt on whether to say the scheme was established to help the poor or not. Some participants' even preferred not to be named as "fee waiver beneficiaries", as they were covering majority of the cost for their medical care at the expense of their children basic needs.

In terms of equal treatment among the paying and FWS beneficiaries, mixed opinions were found from the implementers and waiver beneficiaries. The waiver beneficiaries believe they were discriminated due to the fact that they are not directly bringing cash to the facilities. A study from Ghana also reinforced this concern that the poor included in the pro poor policy were discriminated as they don't directly pay for the services (Dalinjong et al 2012:8). Similarly, a study conducted in Philippines also stated that the equities in health care utilization remained pro rich though pro poor policies are emerging (Paolo et al 2016:7).

However, the health care providers denied these complaints that all patients were served equally without any discrimination. There was no any way that the beneficiaries could be less prioritized as health care providers were able to know who is paying and who is waiver beneficiary. Besides, the health providers believe though the service was free for beneficiaries, it was not free for the health care facilities; a third body will reimburse the total expenditure spent for these beneficiaries. Instead, the study also revealed that health care providers were highly cooperative in terms of supporting the poor patients in various ways such as: bringing drugs from other facilities through loan, contributing money for patients to buy service from private organizations, negotiating with private organizations to serve the poor in reduced cost and treating them as emergency cases were some of the major contributions made by the staffs.

Although this fee waiver scheme was also intended to improve the financial capacity of facilities due to the reimbursed money from the government body, it was not happening as expected. Health facilities were not getting the reimbursements appropriately on timely basis. Health facilities delay in requesting the reimbursements, shifting of the scheme's budget to other activities and poor management commitment were found as the main root cause for these problems.

7.3.4 Financial Protection

The financial protection theme examined the ability of fee waiver scheme in protecting the poor from facing impoverishment due to paying for medical services. Hence, the study revealed that the fee waiver scheme has prevented many poor people from death and from financial impoverishments. The government's investment to improve health care access by the poor was appreciated and some participants even called it one of the most successful government led program that was practically implemented at the ground.

However, though it has saved many poor people from death and financial difficulties, there were significant poor suffering from health and financial crisis. Fee waiver beneficiaries were still forced to pay for health care services to save their life which in turn led them in to financial trouble and compromised basic needs.

This study revealed that waiver beneficiaries buy the drugs by passing their dinners and lunches. Likewise, denying health care service for the sake of children's food and basic needs was common among fee waiver beneficiaries. Parents were scarifying their lives for the survival of their children and family. Lack of drugs, equipment and professionals were forcing the poor either to forgo service or to buy the service from private organizations.

Therefore, Poor program management, monitoring and poor capacity of implementers have caused the indigents to face financial difficulty which was contradicting the underline assumption of the scheme. Lack of clarity on implementation process and poor compliance to the manual has also caused the poor people to face severe financial consequences from out of pocket expenditure or had to forgo the health service (Mathauer et al 2017:1).

This calls the government to give special attention to the poor to protect them from economic crisis due to out of pocket expenditure for UN available service at public health facilities. Evidence based program management, monitoring and evaluation and capacity building activities need to be considered to address these issues.

7.3.5 Performance Management

The performance management component of this study assessed the existence and implementation status of routine monitoring, regular evaluation, accountability and learning systems within the scheme. Hence, this study revealed that lack of proper monitoring, evaluation and accountability systems was one of the poorly practiced components during the waiver implementation. Monitoring and accountability framework was not in place to measure the implementation progress and to ensure accountability of implementing stakeholders.

Lack of performance indicators, lack of planning, monitoring and reporting tools were found during this study. Similarly, most implementing stakeholders had not shared vision, objectives and goals that could enhance the integration and collaboration of these implementers. How the implementers and decision makers are accountable to the public was not clearly indicated in this implementation manual. Nevertheless, WHO (2014:47) states comprehensive set of result framework and performance indicators are key tools for the public to hold the decision makers accountable for what they do in terms of achieving the target.

Although health facilities were led by a board to evaluate performances the facilities every six months, this study found that these board members were not making the implementing stakeholders and facility managers accountable for what they were delivering. Lack of evidences synthesized for decision-making and poor accountability systems have caused this to happen. WHO (2014:42) also consider this as critical for the decision makers at all levels to make the implementing stakeholders accountable.

It was noted that the poor performances and in efficiencies in the different components of the program were caused due to the absence of monitoring, evaluation, accountability and learning systems. Hence, designing effective Monitoring and evaluation system, capacity building activities and promotion of evidence based decision making culture were the major suggested ideas during this study.

7.3.6 Leadership and Governance

The leadership component of this study examined the performances of the coordinating bodies at all levels, the decisions given to guide the performance in the right direction and the government's political commitment to achieve the intended objectives. Since this implementation of fee waiver scheme is a multi-sectorial and multi-stakeholder' mission aiming to save the lives of many poor people, special attention was required from the higher level government bodies for its effectiveness. "In order to effectively implement this reform, it needs policy champions at different levels of the system and objectively delineated roles should be designed for all champions" (Witter et al 2013:8-9).

Nonetheless, the finding revealed that the poor leadership and governance of this scheme took the lion share as main inhibiting factor for almost all of the ineffective components of this scheme. Lack of systems for performances monitoring and evaluation, lack of clarity on the objective and implementation procedures of the scheme among stakeholders, lack of ownership and commitment by the government were among others.

Besides, capacity problems of the implementing stakeholders, poor adherence to the manual, shortage of implementation manual at all levels and lack of trust and acceptability to the manual were also major problems that need the attention of the coordinating bodies. Subjective screening criteria that were made open to be customized by woredas have also caused to have different selection procedures and criteria in the same city. Hence, the coordination bodies need to work to have comprehensive and updated guideline that will commonly work in all woredas.

Similarly, poor decision-making ability by the coordinating body was also causing problems in the fee waiver scheme implementation. According to the study result, proper bilateral agreement was not practiced among regions, facilities and administration offices at all levels which in turn caused for the poor financial reimbursement from administration offices to the health facilities.

Lack of timely and appropriate request from health facilities and lack of money at the woreda or sub city during the requested period caused health facilities suffer from lack of money, which in turn resulted for the compromised provision of health service to the beneficiaries and to the public in general. Poor functionality and in effectiveness of the governing board due to lack of accountability have caused these various challenges to persist and inhibited the implementation progress.

The political ownership and commitment towards the fee waiver scheme was also found to be limited. Woredas, sub cities, and the regional administration offices were responsible to lead the program, through the support of established committees at all levels. However, theses administrators gave priority for other political agendas and left this issue to health sectors only even though the multi-sectoral nature of the program demanded higher coordinating body to effectively manage its implementation.

7.4 FEE WAIVER IMPLEMENTATION FRAME WORK

Based on the findings from phase one of this study, the researcher proposed an implementation framework aiming to address the major barriers for the implementation and effectiveness of the scheme. The implementation framework comprised of six major strategic objectives and twenty-seven core interventions that need to be implemented accordingly. This frame work was initially designed by the researcher and then got validated by experienced and knowledgeable experts on this area. If implemented properly, this implementation framework will play considerable role in improving the health care access by the poor population in the city

7.5 CONCLUSION

This study was conducted with the aim of evaluating the effectiveness of the fee waiver scheme in improving the health care access by the poor segments of the population in Addis Ababa and to propose practical implementation framework. This study was done in two phases where phase one addressed the evaluation component and the second phase addressed the design of the implementation framework. The effectiveness of the scheme was evaluated from the perspectives of the waiver beneficiaries and implementers. Qualitative study approach, using exploratory and descriptive case study

design was used to evaluate the scheme. Health care providers, implementing offices managers, health extension workers, community representatives and fee waiver beneficiaries were the study populations.

The findings of the study were categorized in to six major themes. Three of the themes measured outcomes and three of them measured the enabling environments. The major outcomes themes include population coverage, services coverage and financial protection. The enabling environments include ecological context, performance management and Leadership and governance.

In general, though the commencement of the scheme has benefited considerable indigents in the city, lack of proper implementation process has affected the success of the mission. Lack of integration and coordination, lack of comprehensive monitoring and accountability system coupled with poor governance and decision-making capacity were found as major factors that affected the effectiveness of the scheme from achieving its intended objectives. The population coverage was poor that the intended vulnerable societies in the city were not well addressed. Similarly, the poor capacity of the health facilities in terms of material and human resources along with poor systems administrations forced the health facilities not to provide comprehensive and quality health services to the beneficiaries.

Finally, unable to embrace the needy population in the scheme and poor service coverage at the health facilities haven't protected the poor from facing financial crisis and impoverishments. Most beneficiaries were participated in forced purchase of drugs and services from private organizations at the expense of their families' basic needs. Likewise, some of the beneficiaries were forced to forgo the treatment and went back home to sleep as they have nothing to pay the cost of the medical services. Therefore, the effectiveness of the scheme in improving the health care access for the poor segments of the population in Addis Ababa was compromised.

Consequently, the researcher developed a practical implementation frame work with the aim of addressing the problems and barriers revealed during the study. This framework included six strategic objectives and twenty-seven core interventions categorized under

the six thematic areas. The framework was validated by experiences and knowledgeable experts in the area.

Hence, the implementers and the coordinating body have to review the program design, implementation process, performance management system and its leadership process. achieving the intended objectives of this scheme in particular and the universal health coverage in general wouldn't be possible unless the government gave prior attention to improve health care access for the poor segments of the population. The researcher believed the framework if utilized properly will serve as golden resource and reference for all responsible stakeholders for their immediate decisions and further directions.

7.6 RECOMMENDATIONS

Based on the discovered findings during this study, the researcher would like to indicate the following major recommendations to potential stakeholders for their respective actions. Though most of the major recommendations were included under the strategic objectives and core interventions, it is found mandatory to indicate them as recommendations as well.

In general, the fee waiver implementation limitations and opportunities are going to be addressed if the responsible stakeholders use these evidences for their decision making purposes. Hence, Once, this paper is published, key stakeholders particularly Addis Ababa city administration, and Addis Ababa regional health bureau need to advocate the findings using various approaches such as medias and brochures to influence politicians and policy makers. Besides, there should also be learning platforms and workshops where such findings can be presented and shared to larger audiences. The researcher will also utilize various platforms to share the findings and to influence responsible individuals and organizations. The major recommendation to responsible bodies are provided as follows.

- **Addis Ababa city administration**

  - The design of the scheme need to be contextualized based on the complex and unique nature of the city so that it can address the demand of its population. For example, the management of street dwellers issue and the kebele ID as screening criteria should be revised and contextualized.

  - The existence of governing board at health facilities is a golden opportunity. However, there was no any significant contribution in improving the health care services. Hence, its accountability and effectiveness in making decisions need to be reviewed and improved.

  - The study found that there were significant people slept at home and suffering from financial difficulties due to lack of knowledge about the scheme. Hence, there must be extensive promotions and advocacy through various platforms to address the needy people.

  - The screening committees at woreda level needs to be strengthened and monitored, as lack of fairness during the selection process was one of the weaknesses of these committees.

  - As this fee waiver scheme is a multi-sectorial mission, the ability to coordinate all stakeholders was very weak that needs special attention to make them accountable through regular monitoring and evaluation of their performances.

  - Though the bureau of labor and social affairs was responsible to manage the street dwellers issue, it was not yet addressed. Hence, there must be strategy to address this problem.

- Lack of regular and timely financial reimbursements to the health facilities was one of the problems that caused poor service coverage in the health facilities. This was due to lack of financial capacity to avail necessary inputs. Therefore, the coordinating bodies need to revisit this gap and solve the reimbursement problem.

- Based on the finding, it was also noted that the capitation type of payment could be best in terms of solving the reimbursement problems. So, it is also good to assess and weigh its advantages and disadvantages.

- Since implementing stakeholders' performance and the implementation progress is tracked through robust Monitoring, Evaluation and accountability framework, there must be clear and simple result and accountability system including the list of indicators for all actors.
- There must be strong and regular assessments and joint supportive supervisions, and regular review meetings together with all implementing and coordinating stakeholders to monitor and review the progresses.

- Besides, the evidences of the progress need to be synthesized and provided to the tables of the decision makers.

- As implementing pro poor packages is the key for the achievements of universal health coverage, the government's commitment in terms of resources allocation and implementation follow up need to be his priority agenda.

- There must be adequate human resources at all levels that can follow and monitor the implementation of this scheme.

- As the alignment and coordination of the implementing stallholders is weak, the coordinating bodies must design multi-sectorial coordination and accountability protocol.

- The Bilateral agreement between coordinating bodies and health facilities was found very loose and has caused the health facilities deteriorate their financial capacity as their expenditure was not properly reimbursed. Hence, there must be clear and timely agreement between coordinating bodies and health facilities

- **Addis Ababa regional health bureau**

  - The implementation manual and screening criteria need to be revised and updated

  - Poor understanding of the implementation manual and the screening criteria was found as major barrier for the implementation. Therefore, there must be extensive capacity buildings about the scheme and the screening criteria to all stakeholders at all levels. Similarly, distribution of the implementation manuals and strategies should also be practiced.

  - As there were various types of screening approaches and criteria within the same city that caused for the biased and unfair selection procedures, the coordinating bodies need to have comprehensive and objective screening criteria that can commonly serve for all implementers in all woredas.

  - Since, the health centers were serving for most of the population, the health centers need to be equipped with senior professionals and adequate medical equipment and infrastructures.

  - One of the fore front barriers for the effectiveness of the scheme was lack of drugs in the public health facilities. Hence, the coordinating body, the governing board and the facilities management committee need to work aggressively to avail adequate drugs for the poor.

- The initiative to avail separate pharmacies for fee waiver beneficiaries in health facilities need to be encouraged and expanded to solve the shortage of drugs for the poor.

- The regional health bureau should also conduct agreement with other rural regions as significant patients also come from these regions to Addis Ababa for treatment.

7.7 CONTRIBUTIONS OF THE STUDY

The fee waiver scheme has been implemented in the country for very long time. However, there was no any formal evaluation of the scheme since its launching, though it was considered as one of the big initiatives the government has been implementing to achieve universal health coverage. Therefore, this study gave a big picture and real evidence of the fee waiver implementation for the decision makers and program implementers in the country in general and for AACA in particular. The existing opportunities, key success factors and barriers for its effective implementation were clearly investigated and prioritized.

Based on this study, the researcher has proposed implementation framework comprised of strategic objectives and core interventions. Hence, the government should review, modify and contextualize it as necessary. As the Ethiopian government is striving to achieve universal health coverage, this study finding and the strategies will help the government make evidence based decisions for program implementation, policy developments and resources allocations.

Besides, the researcher believes the finding of this study will also serve as an input for other developing countries that are implementing or planning to implement pro poor or targeted health service packages. Likewise, it will also be valuable evidence for the global scientific community who are working researches on health economics and health service managements. Especially, researchers and institutions working to design and

implement realistic approaches to achieve universal health coverage will find this study very valuable for their work.

7.8 LIMITATIONS OF THE STUDY

This study evaluated the effectiveness of the fee waiver scheme only from the perspectives of the implementers and the beneficiaries. Therefore, the researcher believed it lacks the perspectives of non-beneficiaries to make it comprehensive. Besides, as this study has only employed qualitative study approach, the researcher believes the strength of the finding could have been improved if mixed approach was employed during the study.

7.9 CONCLUDING REMARKS

In general, this study evaluated the effectiveness of fee waiver scheme in improving health care access for the poor segments of the population in Addis Ababa from the perspective of implementers and beneficiaries. Population coverage, services coverage and financial protection among the beneficiaries are explored and findings were analyzed and synthesized for decision makers and researchers.

The research revealed that the scheme has benefited very significant poor population to access health care and prevented them from deaths and financial impoverishments. However, when assessed its effectiveness in terms of population coverage, service coverage and financial protection among the beneficiaries, its intended objective was not yet achieved. Poor governance and coordination, poor implementation capacity, poor monitoring, evaluation and accountability system, and poor infrastructures in the public health facilities were among the key factors that inhibited the effectiveness of the scheme.

Based on these findings, the researcher together with experienced experts has developed and proposed an implementation framework with the aim of addressing the implementation problems. The researcher believed the finding of this study and the established implementation framework will serve as primary references and resources for immediate decisions and further policy directions. Hence, the researcher suggests the

government and the implementing organizations to review and customize the implementation framework as necessary.

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ANNEXES

Annex A. Ethical clearance, University of South Africa, UNISA

UNISA university of south africa

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES
REC-012714-039 (NHERC)

7 December 2016

HSHDC/559/2016
Mr ZM Hagos
Student: 5766-035-2
Supervisor: Prof PR Risenga
Qualification: D Cur
Joint Supervisor: -

Dear Mr ZM Hagos

Decision: Ethics Approval

Name: Mr ZM Hagos

Proposal: Evaluation of the fee waiver system, a health care financing system in Addis Ababa, Ethiopia.

Qualification: DPCHS04

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted for the duration of the research period as indicated in your application.

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 7 December 2016.

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*

Open Rubric

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *[Stipulate any reporting requirements if applicable].*

Note:
The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,

Prof L Roets
CHAIRPERSON
roetsl@unisa.ac.za

Prof MM Moleki
ACADEMIC CHAIRPERSON
molekmm@unisa.ac.za

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
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Annex B. Letter of support data collection, UNISA Akakai campus

UNISA university of south africa

27 NOVEMBER, 2017

UNISA-ET/KA/ST/29/27-11-17

ADDIS ABABA CITY ADMINISTRATION HEALTH BUREAU

ADDIS ABABA

Dear Madam/Sir,

The University of South Africa (UNISA) extends warm greetings. By this letter, we want to confirm that Mr. ZeMichael Mekonen (student number 57660352) is a PhD student in the Department of Health Studies at UNISA. Currently, he is at the stage of data collection on his doctoral research entitled "**Evaluating the effectiveness of fee waiver scheme in enhancing the financial risk protection and improving the health care access to the poor segments of the population in Addis Ababa, Ethiopia**."

This is therefore to kindly request your cooperation in assisting the student in any way that you can. We would like to thank you in advance for all the assistance that you would provide to the student.

UNISA REGIONAL LEARNING CENTRE
PO BOX 13836 ADDIS ABABA ETHIOPIA
TEL +251-114-350141
+251-114-350078
FAX +251-114-351243
MOBILE

Sincerely,

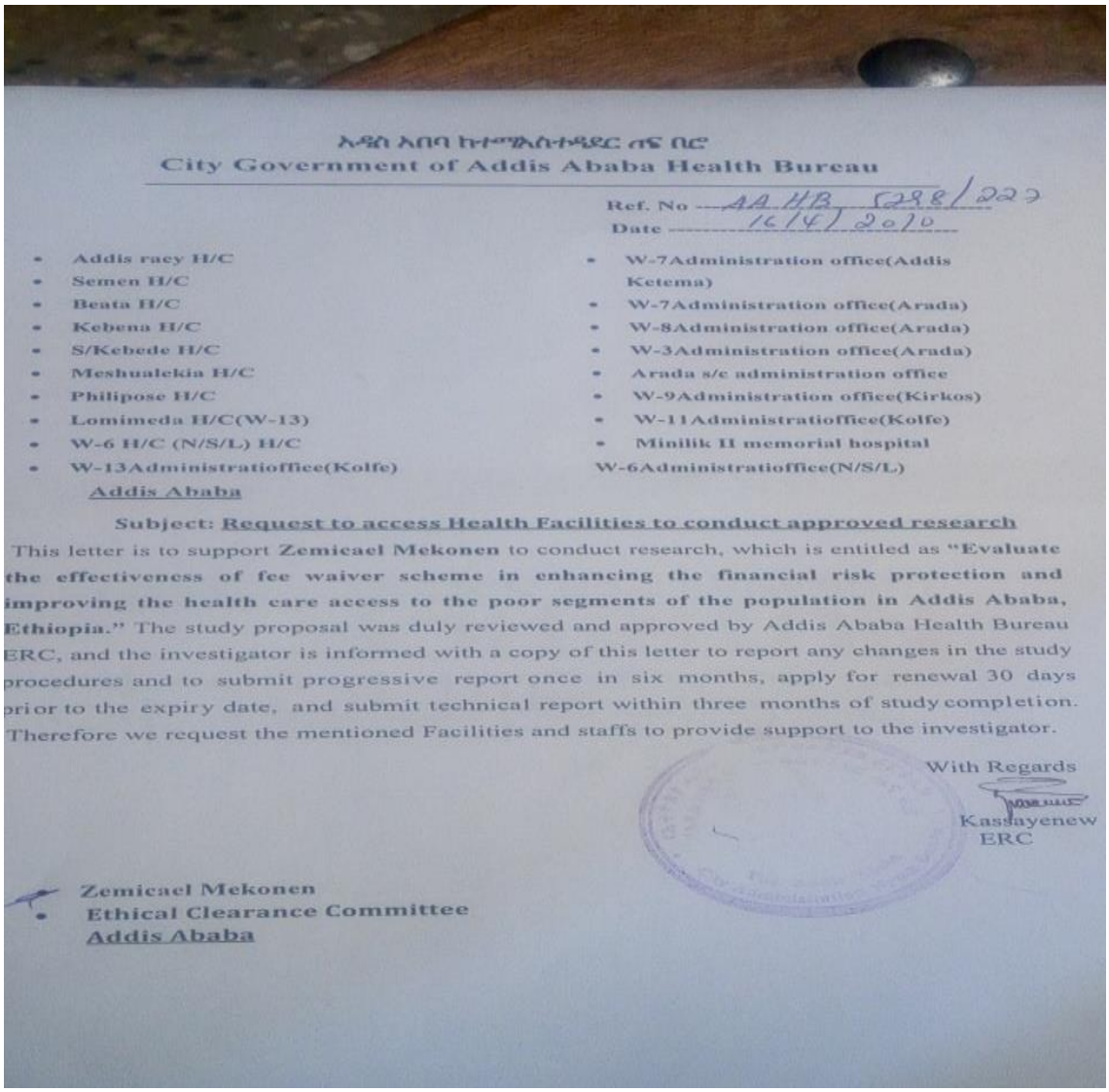
Dr. Tsige GebreMeskel Aberra

Deputy Director – Academic and ICT Support

University of South Africa
Regional Learning Centre
P.O. Box: 13836, Addis Ababa, Ethiopia
Telephone: +251 11 435 2244 / +251 11 435 0078
Facsimile: +251 11 435 1242/ 43/ 44
Mobile: +251 912 19 1483
www.unisa.ac.za

Annex C.: Ethical and cooperation letter, Addis Ababa city

Administration Health bureau, ethical committee



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City Government of Addis Ababa Health Bureau

Ref. No AA HB 5298/229
Date 16/4/2020

- Addis raey H/C
- Semen H/C
- Beata H/C
- Kebena H/C
- S/Kebede H/C
- Meshualekia H/C
- Philipose H/C
- Lomimeda H/C(W-13)
- W-6 H/C (N/S/L) H/C
- W-13Administratioffice(Kolfe)

Addis Ababa

- W-7Administration office(Addis Ketema)
- W-7Administration office(Arada)
- W-8Administration office(Arada)
- W-3Administration office(Arada)
- Arada s/c administration office
- W-9Administration office(Kirkos)
- W-11Administratioffice(Kolfe)
- Minilik II memorial hospital

W-6Administratioffice(N/S/L)

Subject: Request to access Health Facilities to conduct approved research

This letter is to support **Zemicael Mekonen** to conduct research, which is entitled as **"Evaluate the effectiveness of fee waiver scheme in enhancing the financial risk protection and improving the health care access to the poor segments of the population in Addis Ababa, Ethiopia."** The study proposal was duly reviewed and approved by Addis Ababa Health Bureau ERC, and the investigator is informed with a copy of this letter to report any changes in the study procedures and to submit progressive report once in six months, apply for renewal 30 days prior to the expiry date, and submit technical report within three months of study completion. Therefore we request the mentioned Facilities and staffs to provide support to the investigator.

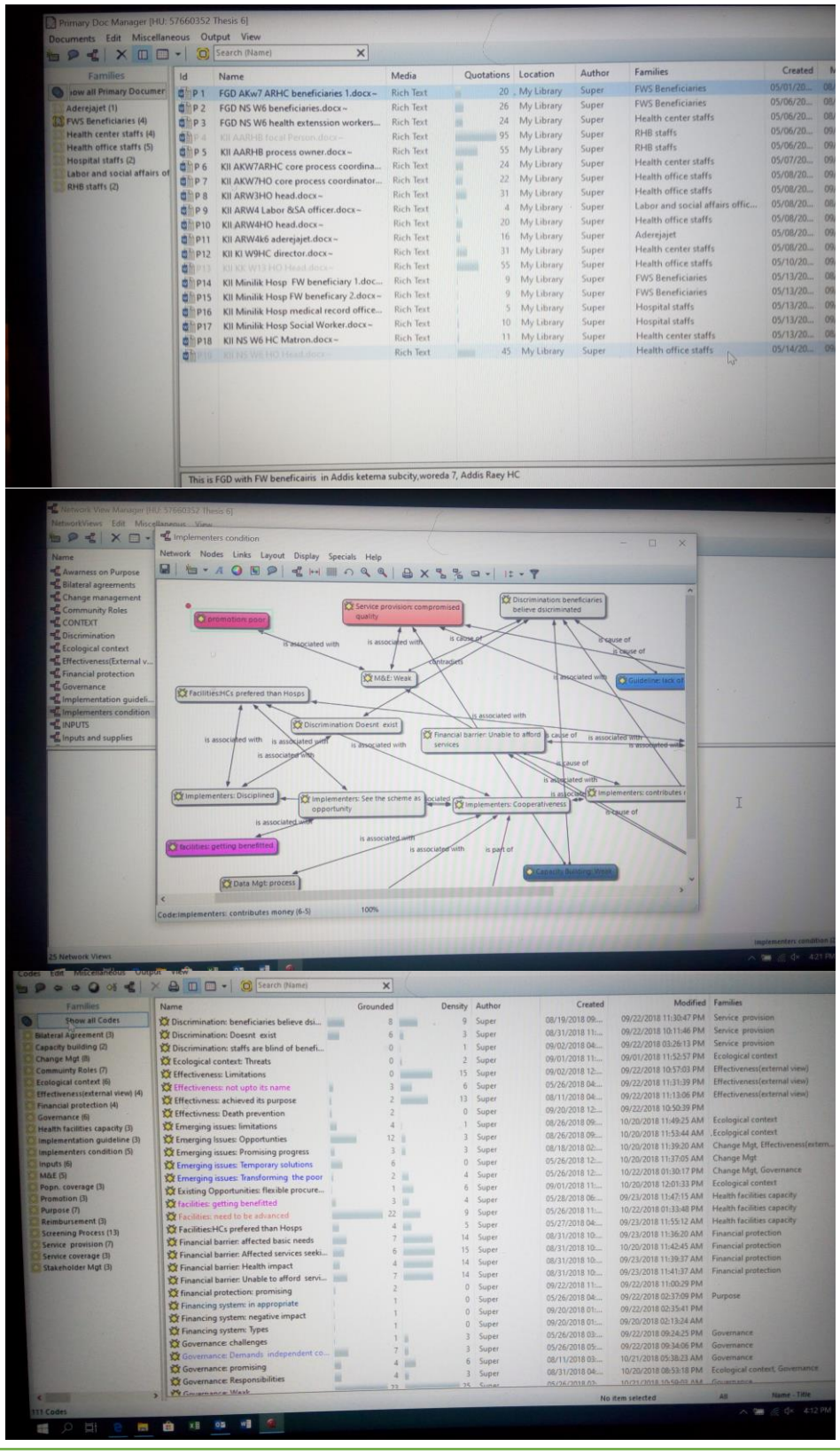
With Regards

Kassayenew
ERC

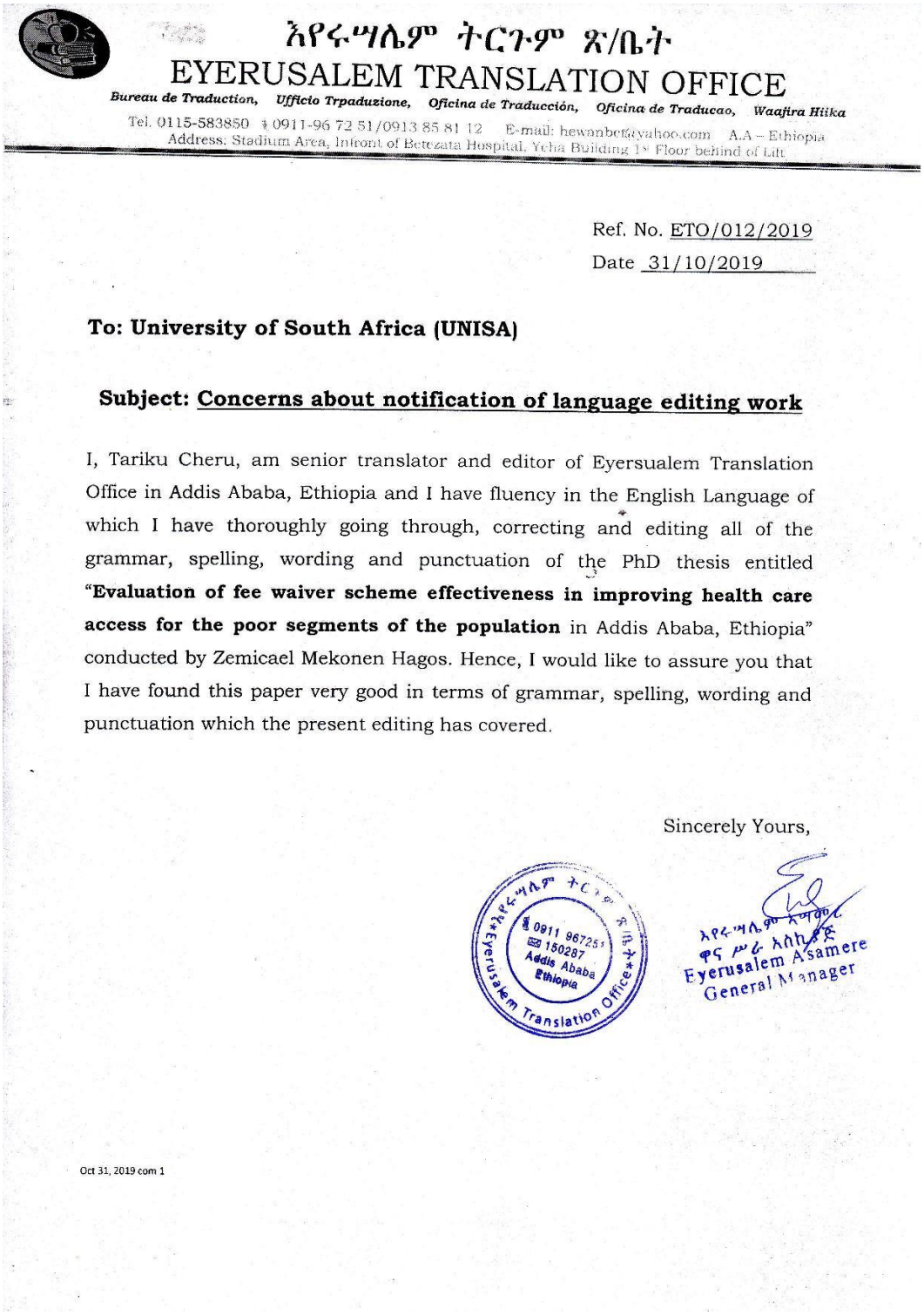
- Zemicael Mekonen
- Ethical Clearance Committee

Addis Ababa

Annex D: Atlas ti analysis: Codes and Network manager Snap shot sample



ANNEX E: Language editing certificate



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EYERUSALEM TRANSLATION OFFICE

Bureau de Traduction, Ufficio Trpaduzione, Oficina de Traducción, Oficina de Traducao, Waajira Hiika

Tel. 0115-583850 ; 0911-96 72 51/0913 85 81 12 E-mail: hewanbet@yahoo.com A.A – Ethiopia
Address: Stadium Area, Infront of Betezata Hospital, Yeha Building 1st Floor behind of Lift

Ref. No. ETO/012/2019

Date 31/10/2019

To: University of South Africa (UNISA)

Subject: Concerns about notification of language editing work

I, Tariku Cheru, am senior translator and editor of Eyersualem Translation Office in Addis Ababa, Ethiopia and I have fluency in the English Language of which I have thoroughly going through, correcting and editing all of the grammar, spelling, wording and punctuation of the PhD thesis entitled "**Evaluation of fee waiver scheme effectiveness in improving health care access for the poor segments of the population** in Addis Ababa, Ethiopia" conducted by Zemicael Mekonen Hagos. Hence, I would like to assure you that I have found this paper very good in terms of grammar, spelling, wording and punctuation which the present editing has covered.

Sincerely Yours,

Eyerusalem Translation Office 0911 967251 150287 Addis Ababa Ethiopia

እየሩሣሌም አሣመረ
ቋና ሠራ አለኸኝ
Eyerusalem Asamere
General Manager

Oct 31, 2019 com 1

ANNEX F. CONSENT FORM FOR PARTICIPATION

IN A STUDYON EVALUATION OF FEE WAIVER SCHEME EFFECTIVENESS IN IMPROVING HEALTH CARE ACCESS TO THE POOR SEGMENTS OF THE POPULATION IN ADDIS ABABA, ETHIOPIA.

You are asked to participate in a research study conducted by Zemicael Mekonen Hagos, a doctoral student at University of South Africa (UNISA).
If you have any questions or concerns about the research, please feel free to contact the investigator: Zemicael Mekonen Hagos (e-mail: zemim86@gmail.com, Tele: +251 913345593

PURPOSE OF THE STUDY

The intent of the study is to evaluate the effectiveness of fee waiver scheme in improving the access for health care by the poor population in Addis Ababa and to develop strategy that could improve the outcome of the fee waiver scheme.

PROCEDURES

If you are volunteer to participate in this study, you will be asked to participate in an in-depth interview or Focus Group Discussion which will take not more than an hour. You will not be identified through your responses.

POTENTIAL RISKS AND DISCOMFORTS

The study will not impose any significant risk for participants except minimal discomfort that might be encountered on FGD especially when dealing with their household economic issue in front of the participants. If you experience discomfort and wish to receive psychological support, please contact the investigator of the study for a referral.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

There will no direct benefit that would be gained by you from attending in this study. However, the results of this study can contribute to the development of health care financing strategy which will help you utilize the health service wisely.

PAYMENT FOR PARTICIPATION

There is no payment for participating in this study.

CONFIDENTIALITY

The information that the investigator collect for this study will be kept confidential. The completed data will be stored in a locked cabinet for five years and will be kept with passwords after five years. The result of this study will be communicated through journals.

PARTICIPATION AND WITHDRAWA

You can choose whether to be in this study or not. If you are not volunteer, you may with draw at any time.

RIGHTS OF RESEARCH PARTICIPANTS

You have full right to with draw your consent at any time and discontinue participation without any consequences. This study has been reviewed and received ethical clearance through UNISA and Addis Ababa Health Bureau. If you have questions regarding your rights as a research participant, please contact the investigator of the study.

SIGNATURE OF RESEARCH PARTICIPANT/LEGAL REPRESENTATIVE

I understand that,

- The information provided by me shall remain confidential,
- My participation is voluntary
- I can choose not to participate in part or all of the project
- I can with draw at any stage without being penalized or disadvantage in any way.

My questions have been answered to my satisfaction, and i agree to participate in this study.

Signature of the participant_____ Date _____

Annex G. Focus Group Discussion (FGD) questions for service beneficiaries

Once again thank you for participating in the Focus Group discussion

1. How do you describe the fee waiver scheme and its importance?

- Meaning and its purposes?
- Starting time of the service?
- Means of awareness creation?

2. Who are the beneficiaries of the scheme?

- Criteria for beneficiaries' selection?
- Availability of Manuals/guidelines?

3. How do you judge the fairness of the selection process? (Leakage)

- Selecting beneficiaries that don't deserve
- Rejecting beneficiaries who deserve

4. What are the types and scopes of the services provided for the beneficiaries?

- Type of services provided
- Scope of the services including referrals and NCDs

5. Are there payments effected from the beneficiaries? If so, how do you describe them?

- For what service is the payment effected?
- How do you see the payment in terms of your ability to pay?

6. **How do you describe the quality of service the beneficiaries are offered with?**

- Beneficiaries satisfaction on quality of service,
- Professionals' ethics and service inputs
- compare with paying patients

7. How do you describe the effectiveness of the scheme in terms of addressing the needy population?

- Do you think there are people suffering from lack of access to health due to financial problem?

8. **How do you describe the effectiveness of the system in terms of addressing the service demand of beneficiaries?**

- Do you think Beneficiaries are getting services based on their need including access for referrals?

9**. How do you describe the effectiveness of the system in terms of protecting the poor from financial loss?**

- Do you think people are facing any financial risk due to health care expenditure?

10. What Challenges do you observe during promoting, selection, implementation and renewal of the fee waiver system?

- Policy, Implementation, and from beneficiaries perspectives

11. Limitation of the system

- How is Dependency syndrome?

12. What interventions, do you suggest to improve effectiveness of the system? In terms of organizational structure, service provision (HF), and policy in general?

- Related to Policy,
- Related to Implementation,
- Related to Beneficiaries

Annex H: In-depth Interview questions for health care providers

Once again thank you for participating in the KII

1. **Tell me about your role with regard to the FWS**
    - **P**osition, roles and responsibilities
    - Service years

2. How do you describe the fee waiver scheme and its importance?

- Meaning and its purposes
- Starting time
- Means of awareness creation

3. Who are the beneficiaries of the program?

- Criteria /manuals/guidelines

4. How do you judge the fairness of the selection process? (Leakage)

- Selecting beneficiaries that don't deserve
- Rejecting beneficiaries who deserve

5. What are the types and scopes of the services provided for the beneficiaries?

- Type of services provided
- Scope of the services including referrals and NCDs

6. Are there payments effected from the beneficiaries? If so, how do you describe them?

- Type of service payment effected?
- Fairness of the payment in terms of ability to pay?

7. **How do you describe the quality of service the beneficiaries are offered with?**

- Beneficiaries satisfaction on quality of service,
- Professionals' ethics and service inputs

- Compare with paying patients

8. What are the requirements of facilities to provide this service?

- Man power, infrastructure, and service type

9. How do you commit contract agreement with the woreda administration?

- How MOU is made
- How reimbursement is made and How often
- Adequacy of the reimbursed amount
- Reimbursement on receipt based or based on number of visits

10. How do you describe the effectiveness of the system in addressing its objective especially in terms of population coverage?

- Is this service addressing all the needy populations?

11. How do you describe the effectiveness of the system in addressing its objective especially in terms of service coverage?

- Do you think beneficiaries are getting whatever services they need including referral services?

12. How do you describe the effectiveness of the system in addressing its objective especially in terms of financial protection?

- Do you think beneficiaries are not facing any financial risk due to health care expenditure?

13. What are the differences between the old and the new fee waiver scheme guideline?

- Advantages and disadvantages?

14. How do judge the program's efficiency?

- Over/ under utilization of allocated resources?

15. How is your data management system?

- Electronic/paper based documentation?

- Data validation process

16. How is the program monitored and evaluated

- Regular monitoring

- Supervision/review meetings

17. Challenges observed during promotion, beneficiaries' selection, program implementation and during renewal processes of the contract?

- Policy, Implementation, and from beneficiaries perspectives

18. Limitation of the system

- Any Dependency syndrome?

19. What interventions, do you suggest need to be implemented in terms of organizational structure, service provision (HF), and policy in general?

- Related to Policy,
- Related to Implementation,
- Related to Beneficiaries

Annex I: In-depth Interview questions for woreda program managers

Once again thank you for participating in the KII

1. **Tell me about your role with regard to the FWS**
    - **P**osition, roles and responsibilities
    - Service years

2. How do you describe the fee waiver scheme and its importance?

- What it is and its purposes
- Who are the beneficiaries?

3. How is the beneficiaries' selection process?

- Establishment of community representatives
- The fairness of the selection process? (Leakage)
- Selecting beneficiaries that don't deserve
- Rejecting beneficiaries who deserve
- Are there criteria's /manuals/guidelines

4. How do you promote the service?

- Meanness of promotion, Media, Home to home?

5. **How do the beneficiaries renew their membership?**

- How often do you revise the list?
- How do you screen new comers?

6. What are the types and scopes of the services provided for the beneficiaries?

- Type of services provided
- Scope of the services including referrals and NCDs

7. Are there payments effected from the beneficiaries? If so, how do you describe them?

- For what service is the payment effected?
- How do you see the payment in terms of your ability to pay?

8. **How do you describe the quality of service the beneficiaries are offered with?**

- Beneficiaries satisfaction on quality of service,
- Professionals' ethics and service inputs
- Compare with paying patients

9. What are the requirements of facilities to provide this service?

- Man power, infrastructure, and service type

10. How do you commit contract agreement with the woreda administration?

- How MOU is made
- How reimbursement is made and How often
- Adequacy of the reimbursed amount
- Reimbursement on receipt based or based on number of visits

11. How do you describe the effectiveness of the system in addressing its objective especially in terms of population coverage?

- Do you think this service is addressing all the needy populations?

12. How do you describe the effectiveness of the system in addressing its objective especially in terms of service coverage?

- Do you think beneficiaries are getting whatever services they need including referral services?

13. How do you describe the effectiveness of the system in addressing its objective especially in terms of financial protection?

- Do you think beneficiaries are not facing any financial risk due to health care expenditure?

14. What are the differences between the old and the new fee waiver scheme guideline?

- Advantages and disadvantages?

15. How do judge the program's efficiency?

- Over/ under utilization of allocated resources?

16. How is your data management system?

- Electronic/paper based documentation?
- Data validation process

17. How is the program monitored and evaluated

- Regular monitoring
- Supervision/review meetings

18. Challenges observed during promotion, beneficiaries' selection, program implementation and during renewal processes of the contract?

- Policy, Implementation, and from beneficiaries perspectives

19, Limitation of the system

- Dependency syndrome

20. What interventions, do you suggest need to be implemented in terms of organizational structure, service provision (HF), and policy in general?

- Related to Policy,
- Related to Implementation,
- Related to Beneficiaries

Annex J: In-depth Interview questions for community Volunteers

Once again thank you for participating in the key informant interview

1. **Tell me about your role with regard to the FWS**
   - **P**osition, roles and responsibilities
   - Service years

2. How do you describe the fee waiver scheme and its importance?

- Meaning and its purposes
- Who are the beneficiaries?

3. How is the beneficiaries' selection process?

- Establishment of community representatives
- The fairness of the selection process? (Leakage)
- Selecting beneficiaries that don't deserve
- Rejecting beneficiaries who deserve
- Are there criteria's /manuals/guidelines

4. How do you promote the service?

- Meanses of promotions, Media, Home to home?

5. **How do the beneficiaries renew their membership?**

- How often do you revise the list?
- How do you screen new comers?

6. What are the types and scopes of the services provided for the beneficiaries?

- Type of services provided
- Scope of the services including referrals and NCDs

7. Are there payments effected from the beneficiaries? If so, how do you describe them?

- For what service is the payment effected?
- How do you see the payment in terms of your ability to pay?

8. **How do you describe the quality of service the beneficiaries are offered with?**

- Beneficiaries satisfaction on quality of service,
- Professionals' ethics and service inputs
- Compare with paying patients

9. How do you describe the effectiveness of the system in addressing its objective especially in terms of population coverage?

- Do you think this service is addressing all the needy populations?

10. How do you describe the effectiveness of the system in addressing its objective especially in terms of service coverage?

- Do you think beneficiaries are getting whatever services they need including referral services?

11. How do you describe the effectiveness of the system in addressing its objective especially in terms of financial protection?

- Do you think beneficiaries are not facing any financial risk due to health care expenditure?

12. How is the program monitored and evaluated

- Regular monitoring
- Supervision/review meetings

13. Challenges observed during promotion, beneficiaries' selection, program implementation and during renewal processes of the contract?

- Policy, Implementation, and from beneficiaries perspectives

14, Limitation of the system

- Any Dependency syndrome?

15. What interventions, do you suggest need to be implemented in terms of organizational structure, service provision (HF), and policy in general?

- Related to Policy,
- Related to Implementation,
- Related to Beneficiaries

ANNEX K: Consent of participation in phase ii frame work validation study

Evaluation of fee waiver scheme effectiveness in improving health care access to the poor population in Addis Ababa, Ethiopia

Dear Colleagues

I would like to request you to participate in a research study being conducted by Zemicael Mekonen Hagos, a doctoral student at University of South Africa (UNISA).

This study has been conducted in two phases: phase one focusing on the evaluation of the Fee Waiver Scheme (FWS) and phase two addressing the framework development. The intent of this (phase II) study is to review and validate the preliminary implementation frame workfor FWS. This frame work comprises of six major strategies and 27 core interventions developed based on the findings revealed during phase one.

The study will not impose any risk for any participant and there will no direct benefit that would be gained from attending in this study. However, the output of this study will contribute for the improvement of health care financing in general and the fee waiver scheme in particular.

Due to your engagement in the implementation and management of health care financing implementations, you are purposively selected to be among the key professionals who can validate this preliminary frame work. The survey is simple and short that will not take more than 20 minutes of your time.

The data will be kept confidential in a password protected situations and there will not be any way that you could be identified by your responses. Findings will be communicated through published journals later on. This study has been reviewed and got ethical clearance from UNISA and from Addis Ababa Health Bureau according to the ethical procedures. Participation is fully voluntarily that you can choose whether to be in this study or not. If you are not interested, you may with draw at any time without any consequences.

If you feel you have any question, feel free to contact the Investigator through e-mail: zemim86@gmail.com, or Tel: +251 913345593.

I understand that the information provided by me shall remain confidential and my participation is voluntary. Hence, i express my agreement to participate in this study via my signature.

Signatureof the participant_____ Date _____

ANNEX L: Validation checklist for the prioritized strategic objectives (SO)

Categories	Description	Experts specific opinion			General opinion
		Relevance (1-5)	Achievability (1-5)	Impact (1-5)	
Theme 1	**Ecological context**				
SO 1.1	Ensure the program is designed based on contextual evidences				
Theme 2	**Population coverage**				
SO 2.1	Improve Stakeholders engagement and management system				
SO 2.2	Standardize the implementation approaches and procedures				
Theme 3	**Services coverage**				
SO 3.1	Improve health facilities capacity to provide comprehensive services				
Theme 4	**Performance management**				
SO 4.1	Improve the Monitoring, Evaluation, Accountability and evidence based decision making systems				
Theme 5	**Leadership**				
SO 5.1	Improve political commitment, governance and multi-stakeholder coordination systems				

ANNEX M: Validation checklist for Prioritized interventions under each Strategic Objective (SO)

Categories	Description	Experts specific opinion					General opinion
		Clarity (1-5)	Specificity (1-5)	Relevance (1-5)	Applicability (1-5)	Impact (1-5)	
SO 1	**Ensure the program design to be based on contextual evidences**						
Intervention 1.1	Conduct feasibility assessments to identify contextual demands, problems and opportunities						
Intervention 1.2	Generate evidences for the design of the program						
Intervention1.3	Pilot the program design in small areas						
Intervention1.4	Develop the program design based on contextual evidences						
SO 2	**Improve Stakeholders engagement and management system**						
Intervention 2.1.	Conduct stakeholders mapping and analysis						
Intervention 2..2	Design protocol for stakeholder engagement and management						
SO 3.	**Ensure Standardization of the implementation approaches and procedures**						
Intervention 3.1	Revise the implementation manual and procedures						
Intervention 3.2	Design standardized beneficiaries screening protocol						
Intervention 3.3	Strengthening capacities of beneficiaries screening committees at all levels						
Intervention 3.4	Strengthening capacity of the implementing stakeholders						
Intervention 3.5	Develop advocacy and promotion procedures						
Intervention 3.6	Design ownership and accountability enhancing systems						
SO 4	**Improve health facilities capacity to provide comprehensive services**						
Intervention 4.1	Develop medical equipment and supplies management protocol						
Intervention 4.2	Equip heath facilities with adequate staffs and necessary materials						
Intervention 4.3	Improve management and governance of health facilities						
Intervention 4.4	Develop capacity building and benefit packages for health care providers						
Intervention 4.5	Assess the feasibility of capitation type of payment to prevent delayed reimbursement process.						
SO 5	**Improve monitoring, evaluation, learning, accountability and evidence based decision making systems**						
Intervention 5.1	Develop monitoring, evaluation, accountability and evidence based decision making protocol						

Intervention 5.2	Design result and accountability framework						
Intervention 5.3	Develop performance management tools						
Intervention 5.4	Conduct regular performances Monitoring and evaluation events						
Intervention 5.5	Strengthen capacity of responsible stakeholders at all levels						
Intervention 5.6	Promote evidence based decision making culture						
SO 6	**Improve political commitment, governance and multi-stakeholder coordination systems**						
Intervention 6.1	Design Advocacy and promotion systems						
Intervention 6.2	Establish effective accountability and performance management system at all levels						
Intervention 6.3	Strengthen governance and coordination capacities						
Intervention 6.4	Revise the financial management process						

Thank you again for committing your time